guidance & counseling services

Crisis Respite Application

Please complete all sections to be considered for the program

Name (*First MI Last*):	**Date of Birth:**	**Date of Referral:**
Are you in a dangerous situation or at risk of harm? ☐ Yes ☐ No *(**If yes, please call 911***)*	**Social Security Number:**	
Preferred phone #: ☐ Home ☐ Cell ☐ Work	**Can we leave a message?** ☐ Yes ☐ No	
Secondary phone #: ☐ Home ☐ Cell ☐ Work ☐ N/A	**Can we leave a message?** ☐ Yes ☐ No ☐ N/A	
Residential Street Address (<u>Agency & Level Of Housing/Dpt./Site</u>, if applicable):	Apt #:	
City:	**State:**	**Zip:**	**County:**
Can you return to this address post-discharge? ☐ Yes ☐ No **Please have someone from your treatment team or family member complete the Residence Confirmation Letter included below **		
Mailing address (if different):		
City:	**State:**	**Zip:**

<u>Required Accommodations</u>

Special Needs: Choose an item.

<u>DSM V Diagnosis/Diagnoses</u> **Need a mental health diagnosis to be considered for this program**

Primary Mental Health Diagnosis: Choose an item.
Do you also suffer from a substance use disorder? ☐ Yes ☐ No **If yes, please specify:**
Do you also have any additional documented disabilities? ☐ Yes ☐ No **If yes, specify:** **(assessing for Intellectual Disability or Developmental Disability)**

Please briefly describe why you are seeking psychiatric crisis intervention services at this time:

Medical Background

Are you taking any medications? ☐ Yes ☐ No *****If yes, please have your psychiatrist or prescriber fill out the Medication Information Sheet (included below) *****
Do you suffer from any physical ailments? ☐ Yes ☐ No **If yes, please specify:**
Do suffer from allergies? ☐ Yes ☐ No **If yes, please specify:**

Health Insurance Information

On date of admission please bring a photo copy of your I.D. and insurance card

Do you have Medicaid? ☐ Yes ☐ No **If yes, please provide Medicaid #:**
Do you have Managed Medicaid? ☐ Yes ☐ No **If yes, please provide Medicaid #:**
Do you have Medicare? ☐ Yes ☐ No **If yes, please provide Medicare #:**
Do you have Managed Medicare? ☐ Yes ☐ No **If yes, please provide Medicare #:**
Do you have private health insurance? ☐ Yes ☐ No **If yes, please provide the following:**

A) **Health Insurance Company:**
B) **Please provide the Member ID #:**
C) **Are you the primary card holder?** ☐ Yes ☐ No
If no, please provide the name and relationship of the primary card holder below.
Name: **Relationship:**

Referral Source

Were you referred to our program by anyone? ☐ Yes ☐ No

If yes, please provide the following:

A) **Name:**
B) **Agency/Hospital:**
C) **Phone #:**

Demographic Information

Gender: Choose an item.	**Marital Status:** Choose an item.
Transgender: Choose an item.	**Sexual Orientation:** Choose an item.
Race: Choose an item.	
Hispanic: Choose an item.	
Preferred Language: Choose an item.	
Are you in or have been in the U.S. Military? ☐ Yes ☐ No	

Emergency Contact Information

Name:		**Relationship:**
Phone #: ☐ Home ☐ Work ☐ Cell		**Can we leave a message?** ☐ Yes ☐ No
Address (if different):		
City:	**State:**	**Zip:**

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Treatment Team and Contact Information

Do you have a Therapist? ☐ Yes ☐ No

If yes, please provide the following contact information:

A) Name:
B) Phone #:
C) Fax:
D) After hours # (if applicable):
E) E-mail:

Do you have a Psychiatrist? ☐ Yes ☐ No

If yes, please provide the following contact information:

A) Name:
B) Phone #:
C) Fax:
D) After hours # (if applicable):
E) E-mail:

Do you have a Care Coordinator? ☐ Yes ☐ No

If yes, please provide the following contact information:

A) Name:
B) Phone #:
C) Fax:
D) After hours # (if applicable):
E) E-mail:

Do you have a Primary Care Physician or Medical Doctor? ☐ Yes ☐ No

If yes, please provide the following contact information:

A) Name:
B) Phone #:
C) Fax:
D) After hours # (if applicable):
E) E-mail:

Do you have a Dentist? ☐ Yes ☐ No

If yes, please provide the following contact information:

A) Name:
B) Phone #:
C) Fax:
D) After hours # (if applicable):
E) E-mail:

Are you in PROS? ☐ Yes ☐ No

If yes, please provide the following contact information:

A) Name:
B) Phone #:
C) Fax:
D) After hours # (if applicable):
E) E-mail:

Do you have an ACT team? ☐ Yes ☐ No

If yes, please provide the following contact information:

A) Name:
B) Phone #:
C) Fax:
D) After hours # (if applicable):
E) E-mail:

Do you have an AOT order? ☐ Yes ☐ No
Are you subject to any court orders or under the jurisdiction of a mental health court? ☐ Yes ☐ No
Are you on probation or parole? ☐ Yes ☐ No

If yes, please provide the following contact information:

A) Name:
B) Phone #:
C) Fax:
D) After hours # (if applicable):
E) E-mail:

Do you have a Financial Manager or Representative Payee? ☐ Yes ☐ No

If yes, please provide the following contact information:

A) Name:
B) Phone #:
C) Fax:
D) After hours # (if applicable):
E) E-mail:

Please print & provide signatures for pages #6 & #7.

Medication Information Update

Applicant _____ is applying to a program in which he/she is encouraged to and
(First & Last Name)
Observed (if needed) ingesting his/her medication. The current medication regimen as prescribed by you is:

*Please attach more sheets if necessary.

1. Please document <u>how many dosages of the aforementioned medication a client can safely miss</u> before you need to be notified:

2. Please document if medication can be resumed at normal scheduled time if missed? (Please check below):

   ☐ Yes

   ☐ No, Explain: _____

3. Should the client skip the next dosage of medications if the client appears intoxicated or under the influence of illicit drugs to CR staff? (Please check below):

   ☐ Yes

   ☐ No

4. Are there any Over the Counter medications which are contradictive with the aforementioned medications? (Please check below):

   ☐ Yes, List: _____

   ☐ No

☐ **Alert: Controlled Substances & Narcotics discouraged.** ***(Check if applicable)***

<u>Medication Monitoring (please check one)</u>:

☐ Can take medication independently

☐ Need medications to be monitored

Office Stamp:

Signature: _____

Print Name: _____

Date: _____

Residence Confirmation Letter

To be completed by someone for your treatment team or family member

Applicant _____ is applying to a program in which the length of stay is **30 days**.
(Applicant's First & Last Name)

The Crisis Respite Program is not considered housing, and therefore, discharges clients to the address listed above as their permanent residence. Due to the restricted length of stay, the Crisis Respite Program is not responsible for finding housing placements. By signing this letter, you are acknowledging that the applicant can return to the address listed above upon discharge from the program. Thank you for your assistance.

_____
Relationship to Applicant

_____
Print Name

_____ _____
Signature Date