



Community Support Program (CSP) Application

- All applications must be **TYPED**; handwritten applications will not be accepted.
- Release of information form must be completed and signed by applicant and/or conservator (see last page) for application to be accepted.
- If applicant has a conservator, conservator decree must be submitted with the application in order for the application to be accepted.
- To submit application, send via fax to Clinical Director, Alessandra Pane, LCSW, at 203-900-3390. For questions, call 203-869-4545 ext. 1004 or email apane@pways.org.

Personal Information:		
First Name:	Last Name:	Medical Record#:
Address:	Town:	Zip Code:
Telephone No:	E-mail:	DOB: Age:
Gender:	Social Security #:	Veteran:
Marital Status:	# of Children:	Does applicant have custody of children?:
Primary Language:		

Contact Information			
Emergency Contact:		Relationship:	
Address:	Home/Cell Phone No:	Work Phone No:	
Therapist/Case Manager Name:		Phone No:	
Psychiatrist Name:		Phone No:	
Medical Physician:		Phone No:	
Conservator of Person:	Address:	Phone No:	E-mail
Conservator of Estate:	Address:	Phone No:	E-mail



Insurance and Finances						
Medicaid #:	Husky: A B C D Check [] [] [] []					
Medicare #:	Part: A B C D [] [] [] []					
Other Insurance Name & Number:						
Principle Source of Support: check	None []	Public [] Assistance	Retirement []	Salary []	Disability []	Other []
SSI: [] Y [] N		SSI Amount:		[] Pending		
SSDI: [] Y [] N		SSDI Amount:		[] Pending		
Cash: [] Y [] N SAGA		Cash Amount:		[] Pending		
SNAP: [] Y [] N Food stamps		SNAP Amount:		[] Pending		
Earnings: [] Y [] N		Earnings Amount:		[] Pending		
Other: [] Y [] N		Other Amount:		[] Pending		
Psychiatric and Substance Use History						
Diagnosis Axis I:			ICD 10 Code		MGAF:	
Diagnosis Axis I:						



Diagnosis Axis II:			
Diagnosis Axis II:			
Diagnosis Axis III:			
Diagnosis Axis III:			
Current Medications related to psychiatric and medical conditions, include PRNs			
Medication	Dose, Frequency, Route	Medication	Dose, Frequency, Route
1.		5.	
2.		6.	
3.		7.	
4.		8.	
<p>Has the individual been psychiatrically hospitalized in the past year? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>If yes, describe precipitants:</p>			
Substance Use History			
Substance Used	Amount/Frequency	Last Used	Age of First Use
<p>Has the individual ever been in substance abuse treatment? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><input type="checkbox"/> Inpatient Detox <input type="checkbox"/> Outpatient Detox <input type="checkbox"/> Residential <input type="checkbox"/> AA/NA or other self help programs</p>			



Safety Information		
Please indicate responses by checking any boxes that apply	Current (past 60 days)	History of:
Violent, homicidal, or threatening behaviors or thoughts?	[]	[]
Aggressive, agitated, or impulsive verbal or physical behaviors?	[]	[]
Fire setting behavior?	[]	[]
Behavior that resulted in a criminal prosecution?	[]	[]
Sexual behavior that posed a risk of dangerousness to the person or others?	[]	[]
Victim of a sexual assault?	[]	[]
Paranoid beliefs or delusions that could lead to harming others?	[]	[]
Command hallucinations that could lead to harming others?	[]	[]
Dangerous behavior related to non-adherence to psychotropic medications?	[]	[]
Non-adherence with treatment for a serious medical condition?	[]	[]
Risk of perpetuating or living with a perpetrator of domestic violence?	[]	[]
Self-injurious behaviors or suicidal statement or actions?	[]	[]
Significant life stressors?	[]	[]
Explain any items checked: Ralph verbally abuses clients and staff of his current residence.		



Medical Information
Has the individual been medically hospitalized in the past year? <input type="checkbox"/> Y <input type="checkbox"/> N
List allergies, seizure history, special diet, special medical conditions:
Date of last physical examination:
Is the person able to self-administer medications? <input type="checkbox"/> Y <input type="checkbox"/> N

Collateral Agencies			
Please list any other providers (nursing, vocational, educational, clinical, etc.) currently working with the person			
Provider Name	Agency Name	Phone	Services Provided

Education & Employment History	
Highest grade achieved:	History of Special Education: <input type="checkbox"/> Y <input type="checkbox"/> N
Title of last 2 jobs held	
Title of Job Held:	Dates of Employment:
Title of Job Held:	Dates of Employment:



Legal Status
Is the person currently <input type="checkbox"/> on probation <input type="checkbox"/> on parole <input type="checkbox"/> involved in an on-going court case
Does the person have a history of incarceration? <input type="checkbox"/> Y <input type="checkbox"/> N

Family & Natural Supports	
What natural supports does the individual have in his or her life? Social supports includes family members, friends, peers, co-workers, spouses or partners, roommates, neighbors, or members of a spiritual or community group.	
List Current Natural Supports	Relationship to the Person

Current Living Situation
Describe the individual's current living situation including current housing, household members, any rental subsidy the person receives, and if they are currently homeless; where are they residing and are they registered in the 211 system?



Service and Rehabilitation Needs	Check	
What functional life skills or rehabilitative needs does the person current have?	Yes	No
Improve housing or living situation		
Improve financial or money situation		
Learn to manage your money better		
Improve relationships with people		
Becoming more social and making new friends		
Improve spiritual or religious practices		
Improve physical health		
Improve your nutrition and food preparation		
Getting and maintaining a job		
Support with transportation		
Increase leisure activities		
Improve personal appearance		
Understanding rights and advocating for needs		
Managing mental health or medical symptoms		
Improving memory, attention or problem-solving skills		
Other:		



AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I, the undersigned, hereby request and give permission to the Pathways, Inc. to (*check one*) release obtain the following medical, psychiatric, drug or alcohol, and/or confidential HIV information from the medical record of:

_____ /_____/_____
 NAME SS # DOB

Check and client initials all appropriate boxes

ck. init. <input type="checkbox"/> <input type="checkbox"/> Discharge/Transfer Summary <input type="checkbox"/> <input type="checkbox"/> Psychiatric Evaluation <input type="checkbox"/> <input type="checkbox"/> Admission Database/ Database Update <input type="checkbox"/> <input type="checkbox"/> Medical History & Physical Exam information, <input type="checkbox"/> <input type="checkbox"/> Drug and Alcohol Information****	ck. init. <input type="checkbox"/> <input type="checkbox"/> HIV information (includes HIV-related tests, HIV counseling, HIV infection, HIV related illnesses or AIDS****) <input type="checkbox"/> <input type="checkbox"/> Other (specify): [Name, contact information, & information on service use]
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(**The confidentiality of this information is specially protected by federal and/or state law. These laws prohibit any further disclosure of the information by the recipient without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.)**

Dates of treatment covered by this release:

The purpose of this disclosure is (check all appropriate boxes):

<input type="checkbox"/> To assist with evaluation and treatment <input type="checkbox"/> Placement/ referral purposes <input type="checkbox"/> Case management coordination	<input type="checkbox"/> Vocational rehabilitation /educational services <input type="checkbox"/> Social Security Disability determination <input type="checkbox"/> Other (specify): _____
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This information will be (*check one*) sent to obtained from the following person or agency (give name & address)

<input type="checkbox"/> <u>Department of Mental Health and Addiction Services</u> <input type="checkbox"/> <u>Social Security Administration</u> <input type="checkbox"/> <u>Department of Social Services, CT</u> <input type="checkbox"/> <u>Greenwich Social Services (Town Hall)</u> <input checked="" type="checkbox"/> <u>Pathways, Inc. 175 Milbank Avenue Greenwich, CT 06830</u>	<input type="checkbox"/> <u>Psychiatrist, _____</u> <input type="checkbox"/> <u>Visiting Nurse, _____</u> <input type="checkbox"/> <u>Primary Care Physician, _____</u> <input type="checkbox"/> <u>Greenwich Hospital</u>
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I understand that I may withdraw this consent, in writing, at any time prior to the release of the above information. I also understand that my revocation of consent to release information does not apply to information already released. This consent, if not withdrawn, will expire on _____ or 1 year from the date below, if not otherwise specified.

_____/_____/_____
 Signature of Client or Person Granting Authorization Date

_____/_____/_____
 Witness Signature Date

175 Milbank Ave • Greenwich, CT 06830 • Tel: 203-869-5656 • Email: Info@pways.org