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 Gayle Paguin, Deputy Executive Director and Clinical Programs Manager, LCSW, at 203-914-5262. For questions, call 203-869-5656 ext. 1004 or email gpaguin@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.	

Has the individual been psychiatrically hospitalized in the past year? [ ] Y [ ] N

If yes, describe precipitants:

Substance Use History

Substance Used	Amount/Frequency	Last Used	Age of First Use

Has the individual ever been in substance abuse treatment? [ ] Y [ ] N

[ ] Inpatient Detox [ ] Outpatient Detox [ ] Residential [ ] AA/NA or other self help programs

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 of 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 perpetuator 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? [ ] Y [ ] N
List allergies, seizure history, special diet, special medical conditions:
Date of last physical examination:
Is the person able to self-administer medications? [ ] Y [ ] 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: [ ] Y [ ] N
Title of last 2 jobs held	
Tile of Job Held:	Dates of Employment:
Tile of Job Held:	Dates of Employment:

Legal Status
Is the person currently [ ] on probation [ ] on parole [ ] involved in an on-going court case
Does the person have a history of incarceration? [ ] Y [ ] 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.

[ ] [ ] Discharge/Transfer Summary
[ ] [ ] Psychiatric Evaluation
[ ] [ ] Admission Database/ Database Update
[ ] [ ] Medical History & Physical Exam
[ ] [ ] Drug and Alcohol Information****

ck. init.

[ ] [ ] HIV information (includes HIV-related tests, HIV counseling, HIV infection, HIV related illnesses or AIDS****)
[ ] [ ] Other (specify): [Name, contact information, & information on service use]

(**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):

[ ] To assist with evaluation and treatment
[ ] Placement/ referral purposes
[ ] Case management coordination
[ ] Vocational rehabilitation /educational services
[ ] Social Security Disability determination
[ ] Other (specify): _____

This information will be (*check one*) [ ] sent to [ ] obtained from the following person or agency (give name & address)

[ ] Department of Mental Health and Addiction Services
[ ] Social Security Administration
[ ] Department of Social Services, CT
[ ] Greenwich Social Services (Town Hall)
[X] Pathways, Inc. 175 Milbank Avenue Greenwich, CT 06830
[ ] Psychiatrist, _____
[ ] Visiting Nurse, _____
[ ] Primary Care Physician, _____
[ ] Greenwich Hospital

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