TOP OPPORTUNITIES & GREEN KEEPERS

61 West 87th Street, Basement
New York, NY, 10024
T: (646) 505-1088
F: (646) 505-1096

Referral Form

Participant Information

Name: ____

Date of Birth: _____________________________ **SSN:** _______________________________

Address: ____ _____; ___________, _____ ______
Street Address / Apt / City / State / Zip code

Phone #: _________________________________ **Cell #:** _______________________________

Primary Language: ______________________ **Email:** _______________________________

Is the participant able to communicate in English? ☐ **Yes** ☐ **No**

Referral Source

Referring Case Manager: _________________________ **Agency:** _____________________

Referring Case Manager Phone #:___________________________, **Extension:** __________

Living Environment

Please indicate participant's current living environment:

☐ **Lives in Own Home** ☐ **Living with Family** ☐ **Transitional Housing**

☐ **Supported Apartment** ☐ **Community Residence** ☐ **Shelter** ☐ **Homeless**

If applicable, please provide the following:

Name of Residence: ______________________________ **Agency:** ______________________

Case Manager at Residence: __________________________________

Residential Case Manager Phone #:___________________________, Extension: _________

How long has the participant lived at current residence? _____________________________

Is the participant planning to move? ☐ Yes, on this date: ____________ ☐ No

Household Composition: ____

Does the participant have children? ☐ Yes ☐ No

Does the child(ren) live with them? ☐ Yes ☐ No

Is there a history of homelessness? ☐ Yes ☐ No

If yes, please indicate time periods of homelessness: _________________________________

Benefits & Entitlements Information

Please indicate participant's benefits/entitlements/insurance and monthly amounts:

☐ SSI $________ ☐ SSD $________ ☐ Veteran's $________ ☐ SNAP/FS $________

☐ HRA $_______ ☐ Other: ____

☐ Medicaid: #_________ ☐ Medicare: #_________ ☐ MBI-WPD $________

Managed Care Organization: ____

Does the participant have Half-Fare MetroCard? ☐ Yes ☐ No ☐ Pending ☐ Ineligible

Has the participant ever earned a paycheck while receiving benefits? ☐ Yes ☐ No

Did they notify/communicate with the Social Security Administration? ☐ Yes ☐ No

Legal History

Has the participant ever been convicted of a crime? ☐ Yes ☐ No

If yes, list dates and convictions, time served, probation, and parole information:

1) TYPE: ________________________ DATES: ___________________ STATE: _______

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2) TYPE: ____________________ **DATES:** ________________ **STATE:** ______

3) TYPE: ____________________ **DATES:** ________________ **STATE:** ______

PROBATION/PAROLE INFO: ____

____

Does the participant have a Certificate of Disposition? ☐ **Yes** ☐ **No** ☐ **Pending**

Does the participant have a Certificate of Good Conduct? ☐ **Yes** ☐ **No** ☐ **Pending**

Does the participant have Record of Arrest & Prosecution? ☐ **Yes** ☐ **No** ☐ **Pending**
(Also known as a Rap Sheet)

Program Involvement

Please list the programs the participant is currently attending, their schedule, and indicate whether the participant will be expected to attend after joining TOPOP/Green Keepers:

____

____

____

Is client on the waiting list for any program? If so, what program, when expected to join and what changes would occur to client's schedule?

____

____

____

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Psychiatric History

Diagnoses descriptions and codes:

Diagnosis Name	ICD-10 Code
______________________	________
______________________	________
______________________	________

❖ **Please be sure to include ICD-10 code.**

List of current medications (dosage, frequency, etc.):

____

____

____

____

Medication side effects that participant complains of:

____

____

Is the participant consistently medication complaint? ☐ **Yes** ☐ **No**

Please describe history of medication compliance:

____

____

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Please describe any history of suicidal or violent behavior: ____________________________

____

____

Please indicate most recent psychiatric hospitalization:

Admitted: _________ **Discharged:** __________ **Hospital Name:** ________________________
From Date To Date

Please indicate *first* psychiatric hospitalization:

Admitted: _________ **Discharged:** __________ **Hospital Name:** ________________________
From Date To Date

Substance Use History

Does the participant have an active substance/alcohol use disorder? ☐ **Yes** ☐ **No**

If yes, please indicate diagnosis and code: ______________________________ _________
Diagnosis Name ICD-10 Code

Does the participant have a history of substance/alcohol abuse? ☐ **Yes** ☐ **No**

If yes, please describe: ____

____

Please describe current substance abuse treatment: __________________________________

____

- ❖ **If active/recent history of substance/alcohol use disorder is indicated, please include authorization for work signed by credentialed alcohol and substance abuse counselor.**

Behavioral Observations

Please describe special behavioral issues: ____

____

____

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Educational History

Please indicate the highest level of education achieved:

☐ **Less than HS: Grade ___** ☐ **HS Diploma, HSE/GED**

☐ **Some College or Associate's** ☐ **Bachelor's Degree** ☐ **Master's or Higher**

Where was the education obtained? ____

Does the participant possess the ability to read? ☐ **Yes** ☐ **No**

Does the participant possess the ability to write? ☐ **Yes** ☐ **No**

Work History

Please provide information regarding the last two employment experiences.

	Most recent position	Second most recent position
Company Name		
Position		
Dates		
Responsibilities		
Reason for Leaving		

Please estimate total amount of work experience: ______ Years ______ Months

Please list previous vocational training: (including any pre-vocational training programs):

____

____

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Describe vocational/educational interests: ____

____

Describe client's task specific abilities and skills: _____________________________________

____

What is the participant's current employment preference or goal?

____

Describe specific strengths in areas of activities of daily living and interactions with others:

____

____

Describe limitations in the areas of activities of daily living and interactions with others:

____

____

Please assess the following skills:

Ability to adapt to change:	☐ **Excellent**	☐ **Good**	☐ **Fair**	☐ **Poor**
Ability to learn:	☐ **Excellent**	☐ **Good**	☐ **Fair**	☐ **Poor**
Reliability/Responsibility:	☐ **Excellent**	☐ **Good**	☐ **Fair**	☐ **Poor**
Self Sufficiency:	☐ **Excellent**	☐ **Good**	☐ **Fair**	☐ **Poor**

Comments: ____

____

Describe any other strengths which could enhance ability to work: ______________________

____

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Describe functional deficits which could influence ability to work: ____________________

____

Other comments: ____

____

____

Referral Source Signature

Referring Case Manager: ________________________ **Agency:** ____________________
Print Name

Referring Case Manager Signature: ________________________ **Date:** ______________

Completed by TOP Opportunities

Reviewed by: _______________________
Deborah Kaplan, LCSW, Director

Comments: ____

____

____

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