

ADULT SERVICES APPLICATION

Date of Application: _____ Referring Agency/Level of Care: _____

Referring Staff/CM: _____ Supervisor: _____

Staff/CM's email address: _____ Staff/CM's phone: _____

Assigned Peer: _____ Peer's phone: _____

LOCUS ID: _____ New Application Stepdown

Referred Level of Care: STR Res Level 1 Res Level 2 Forensic RTF FACT FMT CCT

<i>Applicant Demographic Information</i>		
Name:	DOB:	Gender
Current Address:		
Phone:	Other Contact Info:	SS#:

Diagnosis (please list all- DSM V): _____

Prescribed Medication: _____

Current Legal Status: None Commitment Order Conditional Release Felony MH Probation

Assigned Judge: _____ Next court date: _____

Current living arrangements: Homeless ALF/Group home Family/Friend State Hospital

Department of Corrections (Jail, Prison) Independent housing

Residential Program (Specify): _____

Applicant language preference: English Spanish Creole Other: _____

Income: None SSI SSDI Employed VA Food Stamps OSS Other Amount: _____

Insurance: None Medicaid #: _____ Medicare #: _____

Note: Admissions to STAR are considered a transfer between Baker Act designated receiving facilities. Therefore, the STAR program requires a nurse-to-nurse conference and medical clearance. **Admission date is pending STAR receipt of the above information/documentation and medical clearance from the program.**

Please email this form, a copy of the Eligibility Verification print out, and the signed Confidentiality Release to Concordia Behavioral Health at advocacy.bbhc@concordiabh.com in Broward or fax to (786) 533-2618 for initial authorization.

Referring Staff Signature

Print name

Date

DISCHARGE PLANNING

Prior housing placements: _____

Recommendation for post residential treatment placement: _____

Prior treatment: _____

Recommendation for stepping down to a lower level of care: _____

Please list client's supports: _____

Please list client's current treatment supports: _____

What treatment plan goals have not been met at the currently level of care: _____

Social Security Benefits:

Has this client applied for Social Security benefits? Already Receives SSI

Yes, new application is pending Yes, reinstatement is pending

No, application needs to be completed : Not applicable for this applicant

If application is pending, when was the application submitted: _____

Does the applicant have a ID : Yes or : No

What has been done to expedite the client's benefits: _____
