Allegheny County Department of Human Services
Supported Employment Referral Form

REFERRAL DATE:	SERVICE PARTICIPANT NAME:
Check If INTERNAL REFERRAL ☐	

FORM INSTRUCTIONS

1. Only ***ONE*** service provider may be referred to at a time.
2. Be specific when describing the individual's employment goals and reason for referral.
3. ALL sections must be completed thoroughly and typed in order to make a determination of services.
4. Items should not be left blank; please indicate N/A where appropriate.
5. A verification of a Behavioral Health diagnosis is necessary for provision of services.
6. The signature of the Service Participant is required indicating an understanding that a referral for Supported Employment Services is being made.
7. Fax or email the completed referral to the provider of the Service Recipient's choice from the list below.
8. An individual can self-refer.

REFERRAL SOURCE RESPONSIBILITY

1. If the Supported Employment provider is unable to contact the referred service recipient, the referral source has the responsibility for assisting the Supported Employment provider in contacting the referred individual.
2. The referral source has the responsibility of providing a warm hand-off and introduction between the Service recipient and the new provider.

SUPPORTED EMPLOYMENT PROVIDERS

Mon Yough Community Services

412-346-9798 (Ph)
412- 672-1262 (Fax)
Contact: Heather Lucas
Email: lucashr@upmc.edu

Pittsburgh Mercy

412-488-4377 (Ph)
412-488-4097 (Fax)
Contact: Chekesha Bell
Email: CBell@pittsburghmercy.org

TCV

412-461-3811 ext. 5728 (Ph)
412-464-1796 (Fax)
Contact: Rebekah Yohe
Email: ryohe@tcv.net

A. ELIGIBILITY CRITERIA

1. Persons eligible for Adult Supported Employment Services are 18 years of age or older, who have a Diagnosis within the DSM V (or succeeding revisions thereafter).
2. Individuals referred have a desire to gain competitive employment or receive support in obtaining education that will lead to Competitive Employment.
3. Individuals must be a resident of Allegheny County to receive this service.

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REASON FOR REFERRAL:
MOTIVATION TO WORK:

Name of Provider where referral is being made: <u>ONLY ONE</u> provider may be selected:

☐ Mon Yough Community Services ☐ Pittsburgh Mercy ☐ TCV

Section B. REFERRAL SOURCE INFORMATION

Referral Source:	☐ Psych Rehab ☐ SC ☐ ECSC ☐ OP ☐ Other If Other, describe:		
Referral Source Name:			
Affiliated Agency Name:			
Phone:		Cell:	Fax:
Email:			
Supervisor's Name:		Phone:	Email:

Section C. SERVICE PARTICIPANT INFORMATION

Name:	Last		First	
Alias Name:	Last		First	
Date of Birth:		Age	SS#	
Veteran:	☐ Yes ☐ No	If yes, year of discharge?		Branch:
Permanent Address:	☐ *check here if Homeless*			Zip code
Transportation:	☐ Own vehicle ☐ Bus ☐ Other If other, describe:			
Current Address: (*if someplace other than permanent address)*	Facility Name:	Address:		Phone:
Contact Numbers	Home:	Cell:		Best time to call:
Email Address:				
Accommodations:	☐ TTY ☐ Interpreter ☐ Sign language ☐ Ambulatory limitations			

Accommodations Cont'd:	Other – Document any other special needs or requests the individual may have:

Section D. EDUCATION/WORK/TRAINING EXPERIENCE

Highest Education Completed	**Institution Name**	**Year completed**	**If Other, describe**
Choose an item.			
Desired Work Type:			
Describe Any Work Experience:			
Describe any Certificates/Achievements/Specialized Training:			

Section E. FINANCIAL INFORMATION/SOURCE of INCOME

Monthly Income Amount:	Income Information Unknown: ☐ **(If this is checked, the remainder of section E may be skipped)**	
Source of Income:	☐SSI ☐SSD ☐VA ☐Retirement ☐ Child Support ☐Other:	
If source of income is pending, please describe and give date of application: SOAR Application: ☐ YES ☐ NO Date of application: Additional Information:		
Representative Payee Name: (if applicable) If N/A check here ☐		Phone:
Power of Attorney: (if applicable) If N/A check here ☐		Phone:

Section F. Other Agency/Program Involvement LIST ACTIVE SERVICES:

Please check here if this is an internal referral and move to next section ☐

Program Support: ***(choose from drop-down menu)***	Agency:	Name of primary provider contact:	Phone:	Email:
Choose an item.				

Choose an item.				
Choose an item.				
☐ACSP ☐CSP/CIT	If Applicable to CSP/ACSP please attach plan			

Section G. Mental Health Information *(DSM Diagnosis- Please attach a recent psychiatric evaluation or Doctor's signature to verify diagnosis completed within past 12 months).*

Please include a primary behavioral health diagnosis. Other diagnoses may be included

Behavioral Health:		Code:
Behavioral Health:		Code:
Medical Conditions:		
Medical Conditions:		
Last Psychiatric Eval:		Completed by:
Medications: (please list ALL) OR include med sheet with referral		

Section I. Legal History *(attach additional sheets if needed)*

CRIMINAL CHARGES CURRENT/ PAST 5 YEARS *(choose from drop-down menu)*	**ARREST DATE** (IF APPLICABLE)	**OUTCOME OF ARREST** (IF APPLICABLE)	**RELEASE DATE** (IF APPLICABLE)	**CONVICTED**	**CONVICTION/ DISPOSITION (IF APPLICABLE)** *(choose from drop-down menu)*
Choose an item.		Choose an item.		☐ **YES** ☐ **NO**	Choose an item.
Choose an item.		Choose an item.		☐ **YES** ☐ **NO**	Choose an item.
Choose an item.		Choose an item.		☐ **YES** ☐ **NO**	Choose an item.
Choose an item.		Choose an item.		☐ **YES** ☐ **NO**	Choose an item.

Choose an item.		Choose an item.		☐ YES ☐ NO	Choose an item.
If OTHER Charge Identified Explain:					
Probation or Parole Involved? ☐ **YES** ☐ **NO** **If Yes, Level:** ☐ **County** ☐ **State** ☐ **Federal** P.O. Name: Phone: Email:					

Section J. AUTHORIZATION FORM

I agree to this referral and authorization. In an event I cannot be reached, or additional information is needed, I authorize other service providers or organizations listed on this referral be contacted on my behalf for the purpose of coordinating this referral.

Print Name _____ Date _____

Service Participant Signature _____

Print Name

Guardian Signature _____ Date _____

_____

Print Name _____

Referral Source Signature _____ Date _____