PROGRAMS FOR PEOPLE, INC.

98 Lincoln Street Framingham, MA 01702 TEL (508) 879-3230 FAX (508) 872-8724

Laura Hughes, PMHCNS-BC
Director

Date received: ___/___/___
Date screened: ___/___/___

PROJECT ADVANCE REFERRAL FORM

PROJECT ADVANCE TEL (508) 620-1730 Mary Jane Kunycky, CRC, Employment Services Manager

Please fill out the entire form - do not leave any questions blank

If the individual you are referring already has an MRC Counselor please contact us before completing this form.

Referrant: _____ Date:_____
Organization: _____ Telephone : _____ Fax:_____
Clinician's Signature: _____ License #: _____

The Project Advance Referral form MUST be completed and signed by a Licensed Clinician.
Applicants with a Diagnosed Substance Abuse History must be **SOBER** for a minimum of **3 MONTHS** prior to their referral to the program.

WHAT IS THE APPLICANT'S RESPONSE TO THIS REFERRAL? _____

IDENTIFYING INFORMATION

Applicant's Name: _____ Date of Birth:_____
Home Address: _____ Telephone : _____
Social Security Number: _____-_____-_____

INCOME:	**Source**	**Amount**	**Source**	**Amount**	**Source**	**Amount**
	SSI		Private Disability		Unemployment	
	SSDI		Other		*Family Income	

*Family income may determine eligibility for Mass. Rehabilitation Commission Services

PRESENTING PROBLEMS

DSM III Diagnosis and NO.: (AXIS I): _____
_____

Briefly describe the duration, frequency and severity of symptoms. Include your understanding of major precipitants:

Describe any suicidal / homicidal gestures or attempts:

Explain if any of the following apply to the applicant:
Cognitive Issues: _____
Assaultive Behavior: _____
Involved in court action/and CORI: _____

SIGNIFICANT FAMILY ISSUES:
_____
_____

CURRENT MEDICATIONS (Name of drug, dosage/frequency)
_____ _____
_____ _____

SIGNIFICANT MEDICAL HISTORY AND ALLERGIES: _____
_____

SUBSTANCE ABUSE HISTORY

Name of Substance	Amount of Use	Frequency	Treatment	Date of Last Use

Does applicant consider substance use a problem? Yes: _____ No: _____
What is applicant's commitment to sobriety? _____
What is the plan to attain/maintain sobriety? _____

OCCUPATIONAL CHOICES
List type of job(s) which applicant would like to pursue based on his/her ***current skills*** & interests:

1. _____
2. _____
3. _____

EMPLOYMENT IMPRESSIONS – All categories listed below MUST be completed.
Please list applicant's strengths and weaknesses in **all** of these areas.

[ ] Communication: _____
[ ] Self-Direction: _____
[ ] Interpersonal Skills: _____
[ ] Mobility / Medical Concerns: _____
[ ] Self-Care: _____
[ ] Work Skills: _____
[ ] Work Tolerance: _____

PSYCHIATRIC TREATMENT HISTORY

Name of Hospital	Precipitant(s)	Admission Date	Discharge Date

OUTPATIENT TREATMENT TEAM	**Name**	**Telephone #**
Current Therapist		
Medicating Psychiatrist		

EDUCATION LEVEL/DEGREE: _____ **APPLICANT'S OCCUPATION**: _____

EMPLOYMENT HISTORY (Please list most recent job first):

Name of Company	Title	Dates of Employment	List Barriers on Job	Reason for Leaving

PLEASE FEEL FREE TO SUBMIT ANY INFORMATION THAT YOU BELIEVE WOULD BE HELPFUL IN DETERMINING ACCEPTANCE INTO PROJECT ADVANCE.