CROSSROADS COMMUNITY, INC.
PATH Referral Form

For CCI use only
Service Point #___________
Entered in HMIS__________
☐ Street
☐ Service

Send to: CM Program Coordinator
Crossroads Community, Inc.
120 Banjo Lane
Centreville, MD 21617

Phone: 410-758-3050
Fax: 410-758-1223

CONSUMER INFORMATION

Name____ Date of Birth_____________ Gender ☐ M ☐ F
Address_________________________________City______________________ State_____ Zip Code__________
County___________________ Zip Code of Last Permanent Address__________ Phone #____________________
Alternate Means of Contact ____
Legal Guardian ☐ No ☐ Yes Name ______________________________Phone#________________________

MA#____SS#____

☐ African American/Black ☐ White ☐ Hispanic/Latino ☐ American Indian/Alaskan Native
☐ Asian ☐ Hawaiian/Pacific Islander ☐ Don't Know ☐ Other

Familial Status ☐ Single ☐ Family Veteran Status ☐ Veteran ☐ Non-Veteran ☐ Don't Know

Please all list persons who will need assistance along with consumer (**All information is required to process families**)

Name	Date of Birth	Relationship to Consumer

Currently attending school ☐ Yes ☐ No

Referral Source____________________________Agency_______________________Referral Date____________
Phone #________________________ Fax # _______________________ Email ____________________________

Receiving Mental Health Services ☐ Yes ☐ No
Primary Therapist____ Phone # ________________________

Principle Mental Health Diagnosis (please check **ONLY** one)

☐ Anxiety/Panic Disorder ☐ Personality Disorder ☐ Dual Diagnosis
☐ Bipolar Disorder ☐ Posttraumatic Stress Disorder ☐ Depression
☐ Schizoaffective Disorder ☐ Dementia/Alzheimer's ☐ Schizophrenia
☐ Unknown Mental Illness ☐ Unknown Psychotic Disorder ☐ Eating Disorder

Co-Occurring Substance Use Disorder ☐ Yes ☐ No
Unknown Substance Use Disorder ☐ Yes ☐ No

Current Housing Status (please check **ONLY** one)

☐ Outdoors (street, abandoned or public building, auto) ☐ Hotel, SRO, boarding house
☐ Shelter / Short term (daily or weekly) ☐ Halfway house, residential treatment
☐ Shelter / Long term (over a week) ☐ Institution (psychiatric or other hospital)
☐ Someone else's apartment, room or house ☐ Jail or correctional facility
☐ Domestic Violence Situation ☐ Rental Housing
☐ Other: (explain) ____

Length of time living **outdoors** or in a **short time shelter**_________________

Is client chronically homeless ☐ Yes ☐ No
(Chronically homeless is defined as an unaccompanied individual who has been continuously homeless for a year or more or has had at least four episodes of homelessness in the past three years)

Please provide brief description of current housing situation/what prompted the referral at this time ____________
____
____
____
____
____
____

Special Needs

☐ Mental retardation/developmental disability
☐ HIV+/AIDS & related diseases
☐ Incarceration within past 12 months
☐ Current Juvenile Justice Involvement
☐ Deaf
☐ Hepatitis C
☐ Psych. hosp. within past 12 months
Completed by: ______________________________

Please provide information for each source of income listed below

Entitlements and Financial Resources	**Applied/ Reapplied**	**Ineligible**	**Amount Receiving**
Medical Asst.			
Primary Adult Care (PAC)			
Medicare			
Supplemental Security Income (SSI)			
Supplemental Security Disability Insurance (SSDI)			
Social Security			
Food Stamps			
Temporary Cash Assistance (TCA)			
Public Assistance (PAA)			
Temp Aid to Needy Families (TANF)			
Trans. Emergency Medical & Housing Asst. (TEMHA)			
Child Support			
Veteran's Benefits			
Unemployment Benefits			
Employment Income			
Other (**please specify**):			
No Financial Resources			
		Total Income	

CONSUMER REFERRAL AGREEMENT

I (guardian/self) ____agree to the referral for Project for Assistance in Transition from Homelessness (PATH) Case Management services from Crossroads Community, Inc.

I authorize____ (referral source) to release/exchange information to Crossroads Community, Inc. for the purpose of facilitating the disposition of the referral. I understand that the information exchanged may include the diagnosis, evaluations and records of progress.

I understand that this authorization is valid for one year from the date of signing, and that I may retract it in writing at any time.

Signed: ____ Date:______________________

Parent/Guardian: _____________________________________ Date:______________________