**Cornerstone/Hernandez AFC, Inc.**

**Referral Packet and Intake Form**

Thank you for considering Cornerstone/Hernandez Home AFC,, Inc. We are committed to providing quality services to individuals in need. We have a passion for the industry and those we serve. In order to make a transition as smooth as possible for both us and the consumer we would kindly ask that this information be filled out as accurately as possible.

**Please return the following current documents (if applicable) with this form:**

\_\_\_\_\_\_Current CMH Assessment  
\_\_\_\_\_\_Medication List  
\_\_\_\_\_\_Health/Nursing Assessment   
\_\_\_\_\_\_Release of Information  
\_\_\_\_\_\_ ATO or other treatment order  
\_\_\_\_\_\_Guardianship papers

\_\_\_\_\_\_BTP or Behavior Support Plan

\_\_\_\_\_\_Health Care Appraisal

\_\_\_\_\_\_PC/CLS (3803)

\_\_\_\_\_\_Payee Information

\_\_\_\_\_\_Treatment Plan

\_\_\_\_\_\_OT/PT Information

\_\_\_\_\_\_Identification Sheet

\_\_\_\_\_\_Probation Guidelines

\*\*Please note if you will be contracting with Case Management of MI or other agency for case management and psychiatric services please contact them promptly. This will provide a quick and efficient placement as they will also need to assess this consumer. If you need their contact information or have other questions you can contact Karmen Ball at (269) 348-2708.

**1) Personal Information**  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consumer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Gender:\_\_\_\_\_\_\_\_\_\_\_

Race:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Marital Status:\_\_\_\_\_\_\_\_\_\_\_

Guardianship status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Veteran Status:\_\_\_\_\_\_\_\_\_\_\_\_\_Religion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cultural Background\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary Language\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Court Order: and expiration date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County of Issuing Order:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2) Contacts**  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Agency Contact

Name of individual making referral:

Name of CMH:

Address of CMH:

Email:

Phone Number:

Fax of referral contact:

Fax for incident reports:

Contact in the event of incident:

Current placement Information

Name of individual to contact to assess consumer:

Name of consumer’s current placement:

Phone number:

Address:

Physician

Name:

Address:

Phone:

Email:

Fax:

Psychiatrist

Name:

Address:

Phone:

Email:

Fax:

Guardian

Type of Guardianship

Is Consumer their own guardian? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not, please provide the following for their guardian:

Name:

Address:

Phone:

Email:

Fax:

Is this guardian also their payee/conservator?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not, please provide the following for their payee:

Name:

Address:

Phone:

Email:

Fax:

Next of Kin/Other

Name:

Relationship to consumer:

Address:

Phone:

Email:

Fax:

3) Consumer Care  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies:

Diet:

Contracted Services, please list:

Enhanced staffing requirements (has this client ever been 1:1 or line of sight and are they currently?):

Advanced Directives, please explain:

Does the individual currently have Social Security Benefits and/or Medicaid?

Medicaid ID Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Medicare ID Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Private Insurance ID Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Social Security Information:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does this individual have a state ID?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the consumer under 26 years of age? If so, will they be interested in utilizing a school program?

Aggressive/Maladaptive Behavior (“current” refers to within the last 3 months)

\_\_\_\_\_\_Current\_\_\_\_\_History\_\_\_\_\_\_N/A Physical violence towards other consumers

\_\_\_\_\_\_Current\_\_\_\_\_History\_\_\_\_\_\_N/A Physical violence towards staff  
\_\_\_\_\_\_Current\_\_\_\_\_History\_\_\_\_\_\_N/A Sexual behaviors/inappropriateness

\_\_\_\_\_\_Current\_\_\_\_\_History\_\_\_\_\_\_N/A Property damage

\_\_\_\_\_\_Current\_\_\_\_\_History\_\_\_\_\_\_N/A Public masturbation  
\_\_\_\_\_\_Current\_\_\_\_\_History\_\_\_\_\_\_N/A Verbally sexually explicit  
\_\_\_\_\_\_Current\_\_\_\_\_History\_\_\_\_\_\_N/A Police involvement

\_\_\_\_\_\_Current\_\_\_\_\_History\_\_\_\_\_\_N/A Suicidal attempt

\_\_\_\_\_\_Current\_\_\_\_\_History\_\_\_\_\_\_N/A Suicidal ideation

\_\_\_\_\_\_Current\_\_\_\_\_History\_\_\_\_\_\_N/A Refuses medications

\_\_\_\_\_\_Current\_\_\_\_\_History\_\_\_\_\_\_N/A Auditory/visual hallucinations

\_\_\_\_\_\_Current\_\_\_\_\_History\_\_\_\_\_\_N/A Elopement Risk

Briefly explain these behavioral concerns including approximately when they happened and if any significant damage occurred.

Addictive Behaviors (“current” refers to within the last 3 months)

Smoking \_\_\_\_\_\_\_Current\_\_\_\_\_\_\_\_History\_\_\_\_\_\_\_N/A  
Caffeine \_\_\_\_\_\_\_Current\_\_\_\_\_\_\_\_History\_\_\_\_\_\_\_N/A  
Sugar \_\_\_\_\_\_\_Current\_\_\_\_\_\_\_\_History\_\_\_\_\_\_\_N/A   
Marijuana \_\_\_\_\_\_\_Current\_\_\_\_\_\_\_\_History\_\_\_\_\_\_\_N/A  
Alcohol \_\_\_\_\_\_\_Current\_\_\_\_\_\_\_\_History\_\_\_\_\_\_\_N/A  
Crack \_\_\_\_\_\_\_Current\_\_\_\_\_\_\_\_History\_\_\_\_\_\_\_N/A

Please list current medical concerns and any treatments needed currently (seizures, diabetes, G tube, etc.). Does this consumer require nursing care?

Does this consumer need any assistive devices or special equipment? (glasses, dentures, walker, wheelchair, shower chair, hospital bed, etc.

Are there any barriers we need to be aware of regarding ambulation?

If so, will they have this special equipment at admission or will Cornerstone be responsible to purchase this?

Does this consumer sleep well throughout the night? Describe sleep pattern.

Please list current medications if medication sheet is not attached (Name, Dosage, Frequency).

Are there specific physical plant needs/changes?

Has the Individual been given the choice of provider?

Level of assistance needed

\_\_\_Independent\_\_\_Prompt/Remind\_\_\_Physical Assist Showering

\_\_\_Independent\_\_\_Prompt/Remind\_\_\_Physical Assist Grooming  
\_\_\_Independent\_\_\_Prompt/Remind\_\_\_Physical Assist Money Management  
\_\_\_Independent\_\_\_Prompt/Remind\_\_\_Physical Assist Tells Time

\_\_\_Independent\_\_\_Prompt/Remind\_\_\_Physical Assist Ambulation

\_\_\_Independent\_\_\_Prompt/Remind\_\_\_Physical Assist Transferring

**4. Physical Plant Requirements**

What types of accomodations are required upon admission?

\_\_\_\_\_\_\_Wheelchair Accessible

\_\_\_\_\_\_\_Alarms

\_\_\_\_\_\_\_Fence

\_\_\_\_\_\_1:1 Staffing in the home

\_\_\_\_\_\_ Other, Please Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of supervision does this consumer need in the community?

\_\_\_\_\_\_\_No Supervision  
\_\_\_\_\_\_\_Staff support for health and safety   
\_\_\_\_\_\_\_Staff support for behavioral concerns

If staff support is needed then at what level and why? (1:1, line of sight, 15 minute checks)

If supervision is required due to behavioral or health and safety concerns where will this be outlined?

\_\_\_\_\_Behavior Plan

\_\_\_\_\_IPOS  
\_\_\_\_\_Other, Please Explain:

Details in plan regarding community access:

4. Residential History  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list previous 5 placements of consumer (prior to current placement):

1.

2.

3.

4.

5.

Why was consumer discharged from last placement?

**5. Consumer Choice**

Where would consumer like to reside?

Preference of room décor

Leisure Activities

Staffing Preference

Single or double room preference

What type of roommate would consumer best reside with?

Has the Consumer been notified of potential housemates/roommates and agreed upon services in the environment available?

**Cultural Considerations/Barriers**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. Future Accomodations**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PCP Meeting\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time

BTP Meeting\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time

Medication Review \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time

\*We request that the clinician In-Service the person-centered plan once created, in addition we assume that a person-centered plan will be created within the timeframe allotted in the Michigan Mental Health Code.

Please list any other appointments:

Individual completing report

Print\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sign\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consumer

Print\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sign\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To be Completed by Cornerstone:

Additional information at assessment:

Cornerstone staff assessing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of in person assessment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cornerstone staff reviewing information \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_