



Getting Help...Getting Better...Giving Back.

255 Homestead Avenue
PO Box 320613
Hartford, CT 06132
(860) 263-4400 • Fax: (860) 263-4612
www.ChrysalisCenterCT.org

Dear Service providers:

Attached, please find an application for Chrysalis Center, Inc. Services. You may make copies as needed however, please ensure that you are using the most recent version of the application or acceptance may be delayed. The current version is October 2020. This application **MUST** be filled out by a Clinician/Service Provider. Clinician/Service Provider must complete the application with the participant and send the completed packet with an including documents, either by mail or fax to the:

Intake Department
Chrysalis Center, Inc.
255 Homestead Avenue
PO Box 320613
Hartford, CT 06132
Phone: (860) 263-4401
Fax: (860) 263-4612

Applications for all programs MUST be filled out to its entirety and include:

Requirements for Programs:

- For the REC referrals must come from a therapist/clinician or substance use provider
- For CSP (Skill Building) referrals must come from a therapist/clinician (As they work collaboratively) **Clients MUST remain in clinical services to qualify for the CSP program.**
- Biopsychosocial and/or substance abuse assessment and all diagnosis
- Recent photo ID / Insurance card

Applications for Veteran-related services must also include:

- Local Police Report
- Letter from the clinician that the participant is homeless
- Homeless Verification Form
- Income verification
- Copy of the DD2-14 (Veterans only)

We will notify you with eligibility statuses and regarding any questions. We look forward to working with you and your participant! If you have further questions, please call our Intake Department at the above number.

Please note that we do not offer Housing Programs directly. If you are interested in housing, as per state requirements, you MUST call 211 and go through the CAN process .

Applicant: _____

RECEIPT OF APPLICATION DOES NOT GUARANTEE ACCEPTANCE INTO THE PROGRAM.

SERVICE ASSESSMENT

CHRYSALIS CENTER, INC

HARTFORD, CT 06132

APPLICATION

APPLICANT IS APPLYING FOR WHAT PROGRAM: CSP (Community Support Program)
 REC (Recovery Empowerment Center)

APPLICANT IS IN RECOVERY FROM: MENTAL ILLNESS SUBSTANCE ABUSE BOTH

APPLICANT NEEDS ASSISTANCE WITH:

- | | | |
|---|--|---|
| <input type="checkbox"/> OBTAINING CLINICAL SERVICES | <input type="checkbox"/> MEDICAL PROVIDERS | <input type="checkbox"/> OBTAINING PRENATAL CARE |
| <input type="checkbox"/> MAINTAINING HOUSING | <input type="checkbox"/> HOUSEKEEPING | <input type="checkbox"/> SECURING FOOD |
| <input type="checkbox"/> SECURING HOUSEHOLD GOODS | <input type="checkbox"/> SECURING CLOTHING | <input type="checkbox"/> OBTAINING IDENTIFICATION |
| <input type="checkbox"/> CITIZENSHIP/IMMIGRATION STATUS | <input type="checkbox"/> OBTAINING EMPLOYMENT | <input type="checkbox"/> BUDGETING |
| <input type="checkbox"/> OBTAINING BENEFITS COUNSELING | <input type="checkbox"/> OBTAINING VOCATIONAL TRAINING | |
| <input type="checkbox"/> SECURING INCOME | <input type="checkbox"/> SOCIALIZATION | <input type="checkbox"/> DAILY ORGANIZATIONAL NEEDS |
| <input type="checkbox"/> SECURING SOMEONE TO MAKE FINANCIAL DECISIONS/CONSERVATOR OF ESTATE | | |
| <input type="checkbox"/> SECURING SOMEONE TO MAKE LARGER DECISIONS/CONSERVATOR OF PERSON | | |
| <input type="checkbox"/> HYGIENE NEEDS | <input type="checkbox"/> KEEPING MEDICAL/CLINICAL APPOINTMENTS | |
| <input type="checkbox"/> SECURING ACCESS TO COMMUNITY TRANSPORTATION | | |
| <input type="checkbox"/> DAILY ORGANIZATIONAL NEEDS OTHER: (PLEASE SPECIFY) | | |

APPLICANT IS: PREGNANT RECEIVING CLINICAL SERVICES
 VETERAN WITH CONFIRMED HONORABLE DISCHARGE

DIAGNOSED WITH THE FOLLOWING: MOOD DISORDER PSYCHOTIC DISORDER
 PERSONALITY DISORDER SUBSTANCE DISORDER HIV DISEASE

CONFIRMED TO BE: LIVING IN-SHELTER LIVING ON-STREET LIVING IN SHELTER OR ON-STREET FOR ONE SOLID YEAR
 LIVING IN SHELTER OR ON-STREET FOR AT LEAST 4 EPISODES OVER THE LAST 3 YEARS
 ON THE UNIVERSAL HOUSING APPLICATION LIST
 RECENTLY INSTITUTIONALIZED RECENTLY INCARCERATED
 ON PAROLE ON PROBATION SEX OFFENDER

APPLICANT'S FACEBOOK NAME OR TWITTER TAG: _____

FOR PROGRAM USE ONLY:

PROGRAM ASSIGNED TO/ LEVEL OF SERVICE NEEDED: _____

ASSIGNED STAFF SIGNATURE: _____

Applicant: _____

Chrysalis Center, Inc.

Mail: 255 Homestead Avenue,
PO Box 320613
Hartford, CT 06132

Phone: (860) 263-4401 Fax: (860) 263-4612

Application for Chrysalis Center, Inc. Services

EVERY SECTION ON THE APPLICATION MUST BE COMPLETED.

Application Date: _____

Referral Source:

Please provide referring professional's information below:

Name: _____

Agency/Program: _____

Address: _____

Phone: _____

Email: _____

Applicant Information:

Name: _____

Date of Birth: _____

Social Security: _____

Current Address: _____

Phone #: _____

Aliases: _____ Gender: M F Gender Identity: _____

Religion: _____ Primary Language: _____ Secondary Language: _____

Race: Asian Native American or Alaskan Native
 Black / African/American White/Caucasian
 Native Hawaiian/other Pacific Islander Other (Please Specify)

Unknown

Ethnicity: Hispanic-Other Non-Hispanic
 Hispanic-Puerto Rican Hispanic-Mexican
 Hispanic-Cuban Unknown

Marital Status: Married Never Married Separated Divorced/Annulled Widowed
 Civil Union Other Unknown

Emergency contact: _____

Name: _____ Address: _____

Home Phone: _____ Work Phone: _____ Relationship: _____

Applicant: _____

Dependents: Yes No (If yes, number of dependents and Ages): _____

Do Children Reside with Applicant?

DCF Involvement: Yes No (If "Yes" please give brief explanation)

Plan for Reunification? Yes No (If "Yes" please give brief explanation)

Number of others residing in Household and Relationship to applicant:

Vocational / Educational:

Highest School Grade Completed:

Trade School / College (Please include names of schools, courses, years attended and/or completed):

Are you currently employed? Yes No

(If yes, please give name of employer, dates of employment, job title, duties, and salary)

Financial:

Income Source

Amount Per Month

PT Employment

(Net)

(Gross)

FT Employment

(Net)

(Gross)

No Income

\$0

VA Benefits

Unemployment

Retirement

Public Assistance

Amount Per Month

SAGA

TANF

SSI

SSDI

State Supplement

Food Stamps

Pending Entitlements

Other

Expenses:

Child Support

Student Loan

Alimony

Other

-

Do you have any outstanding bills that you have not made payment on? (e.g. utilities)

Do you have a Conservator of Estate (for financial needs only)? Yes No If yes:

Name of Conservator:

Address:

Phone:

Work Phone:

Fax:

Medical:

Insurance:

No health Insurance

Medicare A (In-pt), B(out-pt),
D (prescription) OR C (Advantage)

Champus (VA)

HMO (Including Managed Medicaid)

HUSKY A, B, C OR D

Other Private Insurance

Self- Pay

Other

Unknown

Insurer:

Policy #:

Policy Holder:

Eligibility Date:

Date of most recent medical review:

Name of current Physician:

Address:

Telephone:

Please list any current/past medical conditions, dates treated, medication and treating physicians:

Applicant: _____

Clinical Information (specify diagnosis version DSM IV-TR or DSM 5 with codes):

Codes	Description	Date of Diagnosis
Axis I	_____ - _____	_____
	_____ - _____	_____
Axis II	_____ - _____	_____
	_____ - _____	_____
Axis III	_____ - _____	_____
	_____ - _____	_____
Axis IV	_____ - _____	_____
	_____ - _____	_____

Axis V (GAF) Present: _____ Past: _____

Medications: Please list all current medications and dosages taken:

Is participant able to self-administer medications? ___ Yes ___ No

If no, is medication monitoring being done? ___ Yes ___ No

If yes, who is doing the monitoring? _____

Please list Clinical Treatment Providers:

Name	Address	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

Behavioral:

Is currently, or have ever been a victim of, or a perpetrator of any of the following behaviors:

	<u>Victim</u>	<u>Perpetrator</u>
<input type="checkbox"/> Domestic/Family Abuse	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Physical Abuse	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Emotional Abuse	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Verbal Abuse	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sexual Abuse	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Inappropriate Sexual Behavior	<input type="checkbox"/>	<input type="checkbox"/>

Please specify & include any legal consequences:

<input type="checkbox"/> Suicidal Behavior	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Homicidal Behavior	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Arson	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____		
<input type="checkbox"/> None		

Applicant: _____

Housing:

Have you ever rented an apartment? ___ Yes ___ No Have you ever owned a home? ___ Yes ___ No

Have you ever been evicted from a living situation? ___ Yes ___ No

If yes, please indicate reason & date: _____

Are you currently homeless or at risk of becoming homeless? ___ Yes ___ No

If yes please explain: _____

If you are currently homeless, how long has this homeless episode been? _____

Current Living Situation:

- Private Residence, participant owns the residence or holds lease.
- Private Residence, friend or relative owns the residence or holds lease.
- Single room occupancy (Hotel, YMCA, Rooming House)
- Private Residence, Community Agency owns or holds lease.
- Residential Care Home/Board and Care
- Congregate Residential Care (24 Hours Supervision, Group setting, Services focused on MH, SA and/or MR issues, Recovery House)
- Crisis/ respite bed
- Skilled Nursing facility/Intermediate care facility/nursing home.
- Psychiatric/SA/Medical Inpatient
- Correctional Facility
- Domestic Violence Shelter
- Homeless Shelter
- Homeless (Including on Street)
- Other
- Unknown

Legal:

Currently on: Probation? Parole? Neither

Under jurisdiction of PSRB? ___ Yes ___ No

Probation/Parole Officer:

Address: _____

Phone: _____

Current arrests or active charges? ___ Yes ___ No

Charges: _____

Court Date: _____

Please List all past charges (include copy of Police Reports) Please include any out of State charges

Do you have a Conservator of Person? ___ Yes ___ No If yes:

Name of Conservator of Person: _____

Address: _____

Home Phone: () _____

Work Phone: () _____

Cell Phone: () _____

Fax: () _____

Military Status:

In which era did the veteran serve in the military?
(Check the **longest** one.)

- Pre -WW II (11/18-11/41)
- WW II (12/41-12/46)
- Pre-Korean (1/47-6/50)
- Korean War (7/50-1/55)
- Between Korean and Vietnam Eras (2/55-7/64)
- Vietnam Era (8/64-4/75)
- Post-Vietnam (5/75-7/90)
- Persian Gulf (8/90-)

Applicant: _____

Substance Abuse:

Does the Participant currently, or have in the past, used/abused any of the following: (If yes, please include dates of first and last use):

<i>Substance</i>	<i>Age of First Use</i>	<i>*Method</i>	<i>Date Last Used</i>	<i>Days Used In last 30 days</i>
<input type="checkbox"/> Alcohol	_____	_____	_____	_____
<input type="checkbox"/> Cocaine	_____	_____	_____	_____
<input type="checkbox"/> Crack/Cocaine	_____	_____	_____	_____
<input type="checkbox"/> Heroin/Opiates	_____	_____	_____	_____
<input type="checkbox"/> PCP	_____	_____	_____	_____
<input type="checkbox"/> Marijuana	_____	_____	_____	_____
<input type="checkbox"/> Amphetamines	_____	_____	_____	_____
<input type="checkbox"/> Sedatives	_____	_____	_____	_____
<input type="checkbox"/> Steroids	_____	_____	_____	_____
<input type="checkbox"/> Barbiturates	_____	_____	_____	_____
<input type="checkbox"/> Hallucinogens	_____	_____	_____	_____
<input type="checkbox"/> Other	_____	_____	_____	_____

* Drug Methods: Oral Smoking Inhalation Injection Other

Substance Abuse Treatment:

Has the client ever been in detoxification for Substance Abuse? ___ Yes ___ No (If yes, please list information below):

Or long-term treatment? ___ Yes ___ No

Facility	Days Attended	Type of Treatment	Completed?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do they believe they have a problem with Substance Abuse/Dependence? ___ Yes ___ No (Please explain:)

Applicant: _____

Describe your greatest strengths, gifts, and abilities: _____

Why do you think you can use our services? Please give a brief statement in your own words:

I certify that the foregoing information is correct and complete to the best of my knowledge and will notify the coordinator of any significant changes.

Signed: _____ **Date:** _____
Participant/Conservator of Person (if applicable)

Signed: _____ **Date:** _____ **Phone #:** _____
Referring Person

RETURN TO:
CHRYSALIS CENTER, INC.
ATTN: Pre-Admission Assistant
255 Homestead Avenue
P.O. Box 320613
Hartford, CT 06132
(860) 263-4400 • Fax: (860) 263-4612

Applicant: _____



Working in partnership with our community and those in need...

255 Homestead Avenue • Hartford, CT 06132-0613 • (860) 263-4400 • Fax (860) 263-4612

AUTHORIZATION TO ENTER PERSONAL INFORMATION INTO CHRYSALIS CENTER DATABASE

PROGRAM: _____

FIRST NAME: _____ **LAST NAME:** _____

DOB: ____ / ____ / ____ **SSN:** ____ - ____ - ____

ADDRESS:

Number and Street _____

Apt/Suite _____

City _____ State _____ ZIP _____

- I understand that by signing this authorization I give **CHRYSALIS CENTER, INC** permission to enter my personal information into their database and all funder required databases.(For Supportive Housing and Freshplace programs I give **CHRYSALIS CENTER, INC.** permission to enter personal information for any individuals who reside in my residence.)
- I maintain the right to choose to have all or just part of my personal information entered into the database.
- I have the right to request that specific personal information I have given be deleted from the database.
- I can ask to see a document which lists the persons who have viewed or updated my participant record.
- If I have any concerns about how my personal data is being used or entered into the database I can contact:

CHRYSALIS CENTER, INC
Attn: CQI Department
255 Homestead Avenue
Hartford, CT 06132

I authorize **CHRYSALIS CENTER, INC** to enter my personal information into its database.
This authorization expires **60 days** after being discharged from **CHRYSALIS CENTER, INC.**

Participant signature

Date

Witness signature

Date