ALTERNATIVES INC
dignity through independence

600 First Ave
Raritan NJ 08869
908-685-1444 x 262
Fax: 908-685-2660

Dear Interested Party,

Thank you for your interest in Alternatives, Inc. Alternatives offers a variety of programs. The **Community Support Services** program is for adults with mental health needs in Somerset County. Services are provided by a team of Licensed Clinicians and Case Management staff who utilize a person-centered approach to help all individuals work on their own personal journey towards recovery. Staff works with each person on developing and actively working on individual goals, in order to enhance life skills and independence within their community. Services are flexible and can be enhanced as needed or requested.

Housing options are also available. These are affordable, shared living opportunities throughout Somerset County. Individuals may also receive Community Support Services without living in this housing. All housing is supportive, we offer no supervised housing or onsite staffing.

Alternatives also serves the homeless population of Somerset County through a variety of housing and services options, including **Franklin House Program** serving homeless mothers and their children. Alternatives also offers **Permanent Housing** and **Rapid Rehousing** options for homeless individuals.

In order for us to schedule an intake, please send the following documentation along with the attached application.

- Income verification: Benefits Award Letter (Grant Statement), Social Security Award Letter, tax returns, 4 recent paystubs (if employed), alimony or child support payments, current bank statement
- Birth Certificate
- State Issued Picture Identification (Driver's License)
- Social Security Card
- Copy of Health Insurance cards
- Sarma Background Check Form
- Recent psychological assessment and current Major Mental Health Diagnosis in ICD-10 form; verification of disability

Depending on the program and need for housing you may be placed upon a wait list if no slots are yet available.

Applications can be returned to:
Emailed to COSReferrals@alternativesinc.org
Mailed to 600 First Avenue Raritan, NJ 08869
Faxed to *ATTN Chelsea E. Decker* (908) 685-2660

If you have any questions, please contact me at (908) 685-1444 x279.

Sincerely,

Chelsea E. Decker, LPC, NCC, ACS, CCATP
Director of Community Outreach Services

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Applicant First Name: _____ M. I.____ Last Name: _____

List all other names you have used. (Examples: Birth name, maiden, previous marriage(s), legal name change, etc.)_____

Phone #:_____ Email: _____

Current Address: _____

Secondary Contact (or Agency Referral): _____ Phone: _____

Address: _____

DOB: _____ SS#: _____ Marital Status: _____ Gender: _____

Children in custody or pending custody (list all – indicate names, gender, ages and custody status):

_____

_____

What program applying for (Check all that apply)

Community Support Services		Franklin House	
Housing only			

Source of Income and Amount (Check all that apply)

SSI		Employment	
SSD		Child Support	
GA		Alimony	
TANF		Veterans Benefits	
Other (describe)			

Insurance Type (Check all that apply)

Medicaid		Private	
Medicare		None	

Veteran Status
Veteran _____ Non-Veteran _____

Medical/Psychiatric Information
Psychiatric Diagnoses: _____
Treatment Provider: _____
Medical/Physical Diagnoses: _____

Current Living Situation (Check that apply)

Own home/ apartment		Rent home/ apartment	
Live with family		Pending homeless/ eviction	
Homeless		Hospitalized	

Are there any characteristics of possible housemates that may be a concern for you?

_____

Legal Information
Have you ever been convicted of a crime? [ ] Yes [ ] No
Have you ever been convicted of a felony? [ ] Yes [ ] No
If yes, please explain: _____

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Current Day Time Activity

Type	Check all that apply	Location	Days attend
Employment			
Volunteer			
Mental Health Program			
Substance Abuse Program			
Educational			
Other(Describe):			

Services/Housing Needs (Check all that apply)

Daily Living Skills Assistance		Linkages to Community Resources	
Money Management		Linkages to Medical/ Psychiatric Services	
Mental Health/ Emotional Counseling		Linkages to Employment Services	
Substance Abuse Services		Linkages to Housing	

How did you hear about us? (Check all that apply)

Family/ Friend		Alternatives Website	
211			
Community Provider (if yes, which one)			
Other (please explain)			

Please tell us in your own words about your need for services:

_____
_____
_____
_____

I understand that in conjunction with my application, Alternatives, Inc. may use the services of an outside agency to research and verify the information I have provided on my application including my personal background, and character. I hereby authorize Alternatives, Inc. to verify any information provided by me in this application and any supplemental attachments, including but not limited to: diagnoses, financial information, criminal conviction record, and residential addresses. I agree, authorize and consent to the release and disclosure of any and all information including but not limited to the above to Alternatives, Inc. and/or any screening service they engage. I understand that the procurement of such reports may contain information as to my background, mode of living, character and personal reputation. By signing below, I authorize that the above information is correct and complete and authorize Alternatives, Inc. to obtain information deemed necessary in the processing of my application as stated above.

Print Name: _____

Applicant Signature: _____

Date: _____

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Dear Provider:

We are requesting some records for the below individual to determine his/her appropriateness for our community case management services. We would like to verify the applicant's recent psychological diagnosis. Individuals diagnosing must have a clinical license such as Ph.D., M.D., APN, PA, APRN, LCSW, LPC, LMFT**.** You can fill out the bottom of this letter to confirm the individual's diagnosis to make it easier or send us the individual's assessment. Your help to expedite this process would be greatly appreciated.
*(*please include all diagnoses and qualifiers -even those not submitted for billing- when applicable to ensure our clear understanding of this patient's case*)

Patient Name:

Patient Date of Birth:

*Current Primary Psychiatric Diagnosis:

Individuals diagnosing must have a clinical license such as Ph.D., M.D., APN, PA, APRN, LCSW, LPC, LMFT

ICD-10 Code	Name of Diagnosis
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____
Provider Printed Name and Credentials **Date**

_____ _____
Provider Signature and Credentials **Date**

_____
Provider's Agency / Practice Name / Phone Number

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