COMMUNITY SUPPORT PROGRAM (CSP)

This section is for CSP to complete:
Auth. #: _____
Dates: _____
Units: _____CSP:_____
Office:_____

Referral Date:
Referral Source:
Referral Contact Information:

Member Information: Name:

DOB: SSN: Gender Identity: Sexual Orientation:

Address: Phone: Language:

Legal Guardian/Custody: Cultural Background:

MMIS: Carrier: Carrier ID:

Please include Carrier ID for Beacon and Tufts-Network Insurances if known

Diagnosis (Include name and code)

Diagnosis	
Medical	

Providers (Continue in last question if additional needed):

Agency/ Provider	Contact Name	Contact Number

Any History of Violence? ☐ **Yes** ☐ **No** **If yes, please describe:**

What are the presenting clinical symptoms?

How do presenting clinical symptoms impact functioning independently in the community?

What are the documented barriers (homelessness, substance use, pregnancy, high ED utilization, etc.)?

What, if any, legal issues are on-going?

Who, if anyone, supports the member?

Please list all current medications including dosage.

Please list with dates recent hospitalizations including medical, detox, and psychiatric admissions, and ED visits.

CSP Goals:

Does the member need to apply for financial assistance (SNAP, Fuel Assistance, etc.)? ☐ Yes ☐ No

Does the member need housing assistance? ☐ Yes ☐ No

Does the member need mental health treatment (current engagement, additional needs)? ☐ Yes ☐ No

Does the member need medical services (current treatment, additional needs)? ☐ Yes ☐ No

Any additional pertinent information regarding member's needs or history?