

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.

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 expedite this referral, please send the following documentation along with the attached application.

- Copy of Health Insurance cards
- Income verification: Welfare Award Letter, Social Security Award Letter, Tax Returns, 4 Recent paystubs if employed, alimony or child support payments, current bank statement
- Birth Certificate
- Picture Identification
- Social Security Card
- Recent psychological assessment and current Major Mental Health Diagnosis in ICD-10 form; verification of disability

Depending on the program in which you apply, there may be a wait list that you are placed upon if no slots are yet available.

Completed applications can be returned by mail to 600 First Avenue Raritan, NJ 08869, faxed to (908) 685-2660, emailed to [bielefeldth@alternativesinc.org](mailto:bielefeldth@alternativesinc.org), or through visiting our website [www.alternativesinc.org](http://www.alternativesinc.org)

Thank you in advance for your cooperation. If you have any questions, please contact me at (908) 685-1444 x279.

Sincerely,

Heather Bielefeldt, LAC  
Director of Community Relations and Admission

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: \_\_\_\_\_

Have you ever received services from Alternatives, or resided in any of the agency's housing in the past?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please provide location, dates, reason for discharge, etc.

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

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: \_\_\_\_\_

**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.

**By signing below, I authorize that the above information is correct and complete and authorize Alternatives Inc. to obtain information it deems desirable in the processing of my application as stated above.**

**Print Name:** \_\_\_\_\_

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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** **Date**

\_\_\_\_\_  
**Provider Signature and Credentials** **Date**

**Provider's Agency / Practice Name / Phone Number:** \_\_\_\_\_

Please either mail the records to Alternatives, Inc. Attention Heather Bielefeldt 600 First Ave Raritan NJ 08869 or fax the records to 908-685-2660.

If you have any questions feel free to contact me via phone at 908-685-1444 ext. 279.

Thank you,

Heather Bielefeldt, LAC  
Director of Community Relations and Admission