**Work First New Jersey**

**Substance Abuse Initiative and Behavioral Health Initiative Referral Form**

(Fax completed forms to 856-338-9199, then call 856-338-9322)

**CWA/MWA Agency: Date:**

**Address:**

**CWA/MWA Caseworker: Phone: Fax:**

**CWA/MWA Supervisor: Phone: Fax:**

**Recipient’s Name:**

**SSN: DOB:**

**Address:**

**City: Zip Code: Phone Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_

**Case Number: Medicaid number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DCP&P (formerly DYFS) NJ Spirit#**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Living Arrangements (EA, etc.):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Status of Individual Being Referred: \_\_\_\_\_\_\_\_\_ GA \_\_\_\_\_\_\_\_\_\_ TANF; \_\_\_\_\_\_\_\_\_ SAIF**

**Check all that apply:**

**Mandatory Non-mandatory Employable**

**Sanctioned Med-1 Deferral (If yes, end date**\_\_\_\_\_\_\_\_\_\_\_\_**), Unemployable**

**60-Month Time Limit Exemption (May or may not have a Med-1 Deferral)**

**Reason for Referral: (Check all that apply)**

**Pre-Assessment** **Checklist Responses** \_\_\_\_\_\_ **Physician Report**

\_\_\_\_\_\_ **Substance Abuse** \_\_\_\_\_\_ **Mental Health**

\_\_\_\_\_\_ **Self Identified Problem** **Convicted of Possession /Use (“Good Cause”)** \_\_\_\_\_\_ **Sanctioned/Intent to Comply** \_\_\_\_\_\_ **Sanctioned/Non-compliance with work activity**

\_\_\_\_\_\_ **Treatment Included in IRP**  \_\_\_\_\_\_ **Positive responses on SAI/BHI questionnaire**

\_\_\_\_\_\_**Drug Court or MAP**

**Names of Children:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Comments:**