Spokane County
WASHINGTON

# Supportive Living Program Referral Request

**Client Name:**_____ **Referral Request Date:** _____

**DOB:**_____ **Marital Status:** _____

**Social Security #:**_____ **Ethnicity:**_____

**Provider One ID#:**_____ **Currently Homeless? Yes** ☐ **No** ☐

**Current Address:**_____ **Phone Number:**_____

**MH or SUD Inpatient or Being Discharged? Yes** ☐ **No** ☐ **Facility?**_____

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**Guardian/POA:** _____ Phone: _____

**Emergency Contact:** _____ Phone: _____

**Payee**: _____ Phone: _____

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**Outpatient Provider Agency**: ☐ CC ☐ CHSW ☐ FBH ☐ LCS ☐ YFA ☐ SPARC ☐ Passages ☐ Native Project ☐ STARS ☐ Other: _____

Clinician Name: _____ Phone & Extension: _____ Email: _____

**Medical Provider Name (PCP)**: _____ Phone: _____

**Diagnosis Codes: (ICD10/DSM5 Format)** **Primary:** _____ **Secondary:** _____ **Tertiary:** _____

**Nursing or Medical Issues** (Please list medical conditions that require medication or special care by staff) Attach Medical History and Physical Assessment, if indicated.

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**Physical limitations:** ☐ Wheelchair ☐ Ambulation Aid (Walker/Cane) ☐ Other: _____

**Household Funding/Income**

- ☐ ABP/ABD (Title 19)
- ☐ TANF (Cash/Food)- Amount: _____
- ☐ SSI (Title 19) - Amount: _____
- ☐ SSA-D/SSDI - Amount: _____
- ☐ Employment Income: _____
- ☐ Other: _____

**Legal Status:** ☐ Voluntary ☐ LRA Expires: _____ ☐ Conditional Release Estimated Release Date: _____

☐ Probation/ Parole (CCO: _____ Expires: _____

**Legal History:** _____

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**Housing Current and History** (List Evictions and Dates): _____

_____

**Behavior History (all boxes must be marked)**

| | Yes | No | Unknown | | Yes | No | Unknown |
|---|---|---|---|---|---|---|---|
| Gambling | | | | Evictions – Explain above | | | |
| Assault without weapon | | | | Fire Setting | | | |
| Assault with weapon | | | | Unsafe Fire Practices | | | |
| Threatens physical harm | | | | Currently Uses Tobacco? | | | |
| Property Damage | | | | Sex Offender | | | |
| Substance Use | | | | HX of suicide attempt/gesture | | | |
| Other History: | | | | | | | |

If yes, please explain or attach documentation (i.e. Psychiatric Assessment or Psychosocial Assessment.)

_____

_____

**Identified Needs of Client**

**Check all that apply:**

☐ Housing ☐ Community Integration Program

☐ Community adjustment and resources
☐ Employment
☐ Grocery shopping
☐ Housekeeping
☐ Health care
☐ Meal planning & preparation
☐ Money Management
☐ Self-care

**Both are required for SLP Services:**

☐ Minimal risk of danger to self, others or property

☐ Program criteria met: Client must be 18 years or older, be RBHO enrolled with a mental health provider, & have an ICD10 diagnosis. Client must be able to be alone for days without supervision and possess basic safety skills (call 911, safe with stove/hot water, etc.) Client must not be in imminent danger or harming self, others, or property. SLP will provide independent living skills training tailored to the client's needs and requests. Client agrees with referral.

**Client understands Supportive Living Program is voluntary?** ☐ **Yes** ☐ **No**

_____ _____

Clinician Signature Date