COMMUNITY SERVICES, HOUSING, AND COMMUNITY DEVELOPMENT DEPARTMENT
Kathleen Torella, Director

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Supportive Living Program/Community Integration Program/ Housing and Recovery Through Peer Services Self-Referral

Individual's Name:____________________ **Referral Request Date:** ________________

DOB:____________________ **Marital Status:** ________________

Social Security #:____________________ **Ethnicity:**________________

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

Current Address:____________________ **Phone Number:**________________

Alternative contact information: ____________________

Have you ever received inpatient mental health or substance use disorder treatment? ☐ **No** ☐ **Yes If yes, what facility(ies) and when?** ____________________

____

Guardian/POA: ____________________ Phone: ________________

Emergency Contact: ____________________ Phone: ________________

Payee: ____________________ Phone: ________________

Are you enrolled in services with another behavioral health agency? ☐ No ☐ Yes – If Yes, please indicate provider below:

☐ CC ☐ CHSW ☐ FBH ☐ LCS ☐ YFA ☐ SPARC ☐ Passages ☐ Native Project ☐ STARS

☐ Other: ____________________

Clinician Name: ________________ Phone & Extension: ____________ Email: ________________

Medical Provider Name (PCP): ____________________ Phone: ________________

***Please complete a Release of Information for all medical and behavioral health providers.**

Behavioral Health Needs: ____________________

____

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

____

Special Accommodations (wheelchair, interpreter, etc.) please describe:

____

____

Any psychiatric, inpatient, crisis stabilization, or substance use disorder withdrawal management or residential treatment in the last year? ☐ No ☐ Yes – If Yes, name of facility(ies) and dates: ____________________

Legal Status: ☐ Voluntary LRA (Expiration date: ____________) ☐ Conditional Release Estimated Release Date: ___________

Housing Current and History (List Evictions and Dates): ____

____

Household Funding/Income

☐ TANF (Cash) Amount: $	☐ Employment Income Amount: $
☐ SSI Amount: $	☐ ABP/ABD Amount: $
☐ SSA-D/SSDI Amount: $	☐ Other (describe): Amount: $

Legal History: ____

____

☐ Probation/ Parole CCO: ______________________ Expires: ______________

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: ____

____

____

Identified Needs of Individual

Service(s) requested:

☐ Supportive Living Services (SLP) ☐ Community Integration Program (CIP)

☐ Housing and Recovery Through Peer Services (HARPS)

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

All are required for SLP/HARPS/CIP Services:

☐ **By signing below I attest that:**

- **I am 18 years or older.**
- **I have a behavioral health diagnosis.**
- **I can be alone for days without supervision**
- **I am a minimal risk of danger to self, others or property.**
- **I possess basic safety skills (call 911, safe with stove/hot water, etc.).**
- **I am Medicaid Eligible and enrolled with a Managed Care Organization.**

☐ **By submitting this form and signing below, I agree to be evaluated for appropriateness for participation in SLP, HARPS and/or CIP programs. Completion of this form does not guarantee services from these programs.**

☐ **By signing below, I acknowledge that at times SLP, HARPS, and CIP programs having waiting lists, and referrals are handled on a first come, first serve basis, unless they are determined to meet criteria for a priority population.**

☐ **As part of services with SLP, HARPS, and/or CIP I understand that I will be required to complete and follow an individualized service plan based on my symptoms and needs.**

☐ **SLP, HARPS, and CIP are voluntary programs and participation is critical to success towards goals. I indicate that this is understood, and I agree to participate in the program, if determined eligible, by signing below.**

Individual's Signature: ______________________________ Date: ____________