



Central New York Services Shelter Plus Care & Supportive Living Program

Pre-Qualification/Referral Form

Date of Referral \_\_\_\_\_

Referring Person \_\_\_\_\_

Referring Agency \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Fax \_\_\_\_\_ Email \_\_\_\_\_

Individual Referred: First/Last Name \_\_\_\_\_

Client's Contact Phone Number: \_\_\_\_\_

Gender: M / F      DOB \_\_\_\_/\_\_\_\_/\_\_\_\_      Social Security # \_\_\_\_-\_\_\_\_-\_\_\_\_

Race \_\_\_\_\_

How many dependents will be living with the referred in a S+C apartment or house? \_\_\_\_\_

How many other non-dependent adults will be living with the referred? \_\_\_\_\_

Disability Status: Does referred have a documented disability?

- |  |  |
|--|--|
| <input type="checkbox"/> Substance Abuse     | <input type="checkbox"/> HIV Positive      |
| <input type="checkbox"/> Mental Health       | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Physical Disability | <input type="checkbox"/> Other _____       |

DSMIV Code \_\_\_\_\_

Has referred ever been enrolled in Shelter Plus Care?  Yes  No

Does referred currently receive a shelter subsidy from DSS or Section 8?  Yes  No

Will S+C household meet HUD “very low income” guidelines? (HH income < \$19,550 for 1 person, < \$22,300 for 2 persons, < \$25,100 for 3 persons, < \$27,900 for 4 persons)

Yes  No

What size apartment is referred looking for?

Studio  1-bedroom  
 2-bedroom  3-bedroom  4-bedroom

What area would referred prefer to live in?

Utica City  Rome City  Other \_\_\_\_\_

What is the referred’s source of income?

Public Assistance (active)  Public Assistance (pending)  SSI/SSD  
 Employment  Other \_\_\_\_\_

The Shelter Plus Care Program requires monthly case management contacts. Does referred have a case manager?

Yes  
 No

If yes, Case Manager Name/Agency/Contact Information:

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Is referred currently receiving mental health services?

Yes

No

If yes, who is their service provider? \_\_\_\_\_

What type of services is referred receiving? \_\_\_\_\_

How long has the referred been in current treatment? \_\_\_\_\_

Is the referred compliant with their treatment plan? \_\_\_\_\_

Is referred currently receiving alcohol or substance abuse treatment services?

Yes

No

If yes, who is their service provider? \_\_\_\_\_

What type of services is referred receiving? \_\_\_\_\_

How long has referred been in current treatment? \_\_\_\_\_

Is the referred compliant with their treatment plan? \_\_\_\_\_

What is your impression of the referred person's ability to function independently? What are their immediate needs? Are there any other comments or concerns?

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Client's Emergency Contact Information:

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

## Participant Eligibility Worksheet

Project Name: \_\_\_\_\_

Participant Name: \_\_\_\_\_

Date of Intake: \_\_\_\_\_

**Type of Homelessness Documentation** (Check the appropriate type of documentation used to verify homelessness and attach it to this worksheet. Maintain these forms in the participant file.)

Homeless Status	Type of Documentation	Documentation Attached
Persons living on the street	A signed and dated general certification from an outreach worker verifying that the services are going to homeless persons, and indicates where the persons served reside.	<input type="checkbox"/>
Persons coming from living on the street (and into a place meant for human habitation)	Staff should provide written information obtained from third party regarding the participant's whereabouts, and, then sign and date the statement.	<input type="checkbox"/>
Person coming from an emergency shelter for homeless persons	Written referral from the agency	<input type="checkbox"/>
Person coming from transitional housing for homeless persons	Written verifications to include program residency and homeless status prior to program entry.	<input type="checkbox"/>
Person from a short-term stay in an institution who previously resided on the street or in an emergency shelter	Written verification from the institution's staff that the participant has been residing in the institution for less than 31 days; and information on the previous living situation.	<input type="checkbox"/>
Persons being discharged from a longer stay in an institution	Written verification from the institution of discharge within one week of receiving homeless assistance AND documentation of income, efforts to obtain housing, and why person would be homeless without assistance.	<input type="checkbox"/>
Persons fleeing domestic violence	Written, signed, and dated verification from the participant.	<input type="checkbox"/>

Notes:

Staff Member: \_\_\_\_\_ Date: \_\_\_\_\_

Participant: I verify this information is true and accurate. I confirm that I have been or am about to be homeless.

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

**Client Disability: Eligibility Documentation**

Participant Name: \_\_\_\_\_ Date of Intake: \_\_\_\_\_

Check the current status and attach the appropriate documentation to verify disability

<b>Disabling Condition</b>	<b>Type of Documentation</b>	<b>Documentation Attached</b>
<u>Any</u>	Income from US Social Security Administration based on disability-SSI/SSD, Statement or copy of check.	<input type="checkbox"/>
<u>Serious Mental Illness</u>	Documentation (diagnosis) from a credentialed psychiatric professional (i.e., psych/social signed and dated.	<input type="checkbox"/>
<u>Chronic Substance Abuse</u> -Must be documented history and must impeded ability to live independently	Documentation and diagnosis from a credentialed psychiatric or medical professional trained to make such determination.	<input type="checkbox"/>
<u>HIV+/AIDS or AIDS related disease</u> -Must impede ability to live independently	Documentation including diagnosis from a credentialed medical professional that is trained to make such determination	<input type="checkbox"/>
<u>Physical Disability</u> -Must be long-term and of indefinite duration; substantially impedes ability to live independently	Documentation including diagnosis from a credentialed medical professional.	<input type="checkbox"/>
<u>Developmental Disability</u> -Severe and chronic. Attributable to mental or physical impairment; manifested before 22yrs. Old and results in substantial functional limitations.	Documentation including diagnosis from a credentialed psychiatric or medical professional that is trained to make such a determination.	<input type="checkbox"/>
<u>Other Mental or Emotional Impairments</u> -Requires combination or long-term care/treatment	Documentation including diagnosis from a credentialed psychiatric or medical professional that is trained to make such a determination.	<input type="checkbox"/>
<u>Other: (Explain)</u>		<input type="checkbox"/>
<u>Chronic Homelessness</u> -Single, disabled adult + Continuously homeless for 1 year or 4 or more episodes of homelessness in the past 3 years (streets/shelters)	Written verification from outreach workers, shelters and brief, written statement regarding previous shelter/street stays (dates, locations) and disability documentation.	<input type="checkbox"/>

Notes:

Staff Member: \_\_\_\_\_ Date: \_\_\_\_\_

Participant: I verify this information is true and accurate. I confirm that I have been determined disabled.

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

**Checklist of Items Needed for a Complete Referral**

Type of Documentation	Documentation Attached
A complete 5 page referral packet ( <b>this must be completed by a community provider, no self-referrals will be accepted</b> ).	<input type="checkbox"/>
Homelessness Documentation ( <b>pg. 4 of referral packet</b> ) signed and dated by staff member and referent.	<input type="checkbox"/>
Disability Documentation ( <b>pg. 5 of referral packet</b> ) signed and dated by staff member and referent.	<input type="checkbox"/>
Proof of Income (i.e. Public Assistance Budget or proof of application for Public Assistance or 1 month of current and consecutive pay stubs from wages earned or the current year's SSI/SSDI award letter)	<input type="checkbox"/>
Letter from current treatment provider with Mental Health and/or Substance Abuse diagnosis code and compliance with treatment ( <b>must be on company letterhead</b> )	<input type="checkbox"/>
Letter stating status of homelessness from current residence (i.e. emergency shelter) ( <b>must be on company letterhead</b> )	<input type="checkbox"/>

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