Helio Health 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?

☐ Substance Abuse ☐ HIV Positive

☐ Mental Health ☐ Domestic Violence

☐ Physical Disability ☐ 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:

_____

_____

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?

_____

_____

_____

_____

_____

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.	☐
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.	☐
Person coming from an emergency shelter for homeless persons	Written referral from the agency	☐
Person coming from transitional housing for homeless persons	Written verifications to include program residency and homeless status prior to program entry.	☐
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 that 31 days; and information on the previous living situation.	☐
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.	☐
Persons fleeing domestic violence	Written, signed, and dated verification from the participant.	☐

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

Disabling Condition	Type of Documentation	Documentation Attached
Any	Income from US Social Security Administration based on disability- SSI/SSD, Statement or copy of check.	☐
Serious Mental Illness	Documentation (diagnosis) from a credentialed psychiatric professional (i.e., psych/social signed and dated.	☐
Chronic Substance Abuse -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.	☐
HIV+/AIDS or AIDS related disease -Must impede ability to live independently	Documentation including diagnosis from a credentialed medical professional that is trained to make such determination	☐
Physical Disability -Must be long-term and of indefinite duration; substantially impedes ability to live independently	Documentation including diagnosis from a credentialed medical professional.	☐
Developmental Disability -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.	☐
Other Mental or Emotional Impairments -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.	☐
Other: (Explain)		☐
Chronic Homelessness -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.	☐

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 **(this must be completed by a community provider, no self-referrals will be accepted).**	☐
Homelessness Documentation **(pg. 4 of referral packet)** signed and dated by staff member and referent.	☐
Disability Documentation **(pg. 5 of referral packet)** signed and dated by staff member and referent.	☐
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)	☐
Letter from current treatment provider with Mental Health and/or Substance Abuse diagnosis code and compliance with treatment **(must be on company letterhead)**	☐
Letter stating status of homelessness from current residence (i.e. emergency shelter) **(must be on company letterhead)**	☐

Helio Health

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