CITY OF PHILADELPHIA
DIVISION OF SOCIAL SERVICES
DEPARTMENT OF BEHAVIORAL HEALTH AND INTELLECTUAL disABILITY SERVICES

DBHIDS INTEGRATED INTAKE APPLICATION PACKET

The Department of Behavioral Health and disAbility Services has developed a single intake for all contracted Behavioral Health Services. This intake will soon be available for on-line submission on our website at www.dbhids.org/. Please use these instructions to assure the accurate completion of this comprehensive form.

Application Attachments

- All Forms required to complete the DBHIDS Integrated Intake:
  - DBHIDS Integrated Intake (6 pages)
  - Authorization to Obtain, Use and Disclose Health Information (1 page)
  - Criminal History and Needs Assessment (2 pages)
  - Psychiatric Evaluation (1 page)
  - Medical Evaluation (1 page)
  - Accompanying Priority Group Documentation (1+ pages)

Other forms for reference:

- Veteran Types of Discharge
- DBHIDS Codes used for Integrated Intake
- Dr. Evans August 20, 2012 Memorandum on Office of Mental Health Residential System Changes
- Prescreening Protocol, including Additional Services and Housing Resources
  - The Prescreening Protocol is for your use and review; please use this tool prior to submitting a comprehensive application to assure the applicant meets all criteria.
- Chronic Homeless Definition
- Common Abbreviations used in Behavioral Health System
- Glossary of Terms used in Behavioral Health System
- Completion Guide for the DBHIDS Integrated Intake

PLEASE NOTE: Submission of this application does not guarantee placement in a residential program.

The provision of Behavioral Health Residential services is not an entitlement under the State OMHSAS, or under Health Choices and resources remains quite limited. Please refer to the DBHIDS Prescreening Protocol (attached) before completing a full application for Community Residential Services. If your predetermination review indicates this person is appropriate for referral for Community Residential Services, please complete the application. The Office of Mental Health and its Transitions, Integration, and Partnerships (TIP) Unit for Mental Health Residential Services will make every effort to review this application in a timely manner and inform the referral source whether there are resources, and when a resource may become available. It remains the responsibility of the referral source to find alternative residential services.

Referrals for adult Behavioral Health Case Management must be mailed to:
Targeted Case Management Unit - 520 N. Delaware Ave - 4A, Philadelphia, PA 19123

Please print clearly or type all pages of the application. Illegible forms will be returned as incomplete. All items on all forms must be completed, and completed according to indicated answer formats; for example, dates must be given as mm/dd/yyyy. Most items are self-explanatory; please refer to the explanations below for clarification on terminology.

Priority Group Documentation:
Documentation of Criminal Mental Health Court or Prison MH Reentry programs is required for incarcerated participants. Applications for homeless participants must be accompanied by either: an Outreach Contact Report, generated by the Homeless Outreach Coordination Center (215-232-1984); a Family Program History (Shelter POS history) Report from the HMIS database through the Office of Supportive Housing; or a letter of residency from a current stay at an OSH Housing Inventory Chart Emergency or Transitional Housing Program, on letterhead of the agency that manages the site.

DBHIDS INTEGRATED INTAKE
APPLICATION PACKET DIRECTIONS

Page One

Referral Contact Person -- Please provide the contact that would receive questions or decisions on this application.

Participant Name: (Last/First/Middle): Please print (No nicknames).

AKA Type: Fill in either-- Alias; Former Name; Maiden Name; Birth Name; Married Name; Other; Error

Address: Participant's permanent address --Please indicated where the personal is living if they are currently in the community, or if they are not in the community, the most recent place they were living.

Gender: (1)Male (2)Female (3)Transgender (4)Male to Female (5)Female to Male (6)Intersex (7)Genderqueer

Ethnicity Code: Fill in either Hispanic or Non-Hispanic

Race: Fill in one of the following: Refused to answer; Black/African American; Alaskan Native; Native American/American Indian; Asian; Bi-racial/mixed; White/Caucasian; Pacific Islander/Native Hawaiian; Other; Unknown

Sexual Orientation: (1) Heterosexual (2) Lesbian (3) Gay (4) Bisexual (5) Asexual (8) Other (9) Unknown

Date of Birth: Include full year-- e.g. 1967

BSU Status: Enter BSU Number if the person is registered with a Community MH/IDS Center

CIS#: CBH Client Identification Number, if the person is registered with CBH

Insurance Carrier: The Participant's Physical Health HMO. Include "Private" or "MA". If there are multiple carriers, please indicate Primary and Secondary. If Participant is uninsured, write NONE.

Income Source(s): Participant's income source (SSI, SSA, SSDI, VA, Name of employer, etc.); indicate AMOUNT of monthly Income on following line. List all forms of income by type.

Name of Payee: Name of person officially designated to receive SSI, SSDI or other payments.

Veteran Status: Please indicate if the participant is a veteran; if s/he is, list the type of discharge and indicate whether s/he is VA Behavioral Health benefit-eligible, using the attached instructions.

Personal Identification Forms: Please indicate what forms of identification you currently have. Please note these forms are very important to maintain at all times.

Current Living Environment: Please use the Codes for Living Environment listed later in these instructions. This code applies to where the person is currently staying at the time of referral. A homeless person staying on an EAC Unit should be listed as code 19—EAC Unit.

Page Two

Current Hospitalization/Incarceration: Please list the name of the facility, the Admit Date and Anticipated Discharge Date. Please also list the Facility Contact name, title, and phone number.

Psychiatric Assessment: Please list details on All Axes. Use Axis Codes from ICD9/DSM IV TR Manual and written diagnosis for Axes I and II. Axis Codes must match those recorded on the accompanying Psychiatric Evaluation.

Page Three

Medical Issues/Physical Disabilities: For each physical and/or medical challenge listed, please provide an indication of whether it is episodic, chronic, or acute and whether there has been recent treatment.

Substance Use/Abuse: If, in the last year, there has been any substance use/abuse, all of the following questions must be completed in their entirety to assure the PCPC assessment can be completed.

Forensic System Involvement: If "Yes is checked for a question, the rest of the info for that question is required. The Criminal History and Assessment Form must be completed and accompany this application.

Page Four

Family Status: Provide info on whether or not the participant has children. If the person has children, the rest of the info is required: total number of children, the number of custodial children, and number of dependent children.

Behavioral Risk Factors: Behaviors listed as anything other than "Not at all" must be accompanied by a date of last instance and a written description of the circumstances and assistance needed to manage the behavior.

Page Five

Meaningful Life Activities: Assess the skills and need for supports under each area.

Psychosocial; Educational/Vocational; Social/Recreational/Leisure Areas:
Please indicate all activities under each area, as well as desired activities. See DBHIDS Codes used for Integrated Intake attached. At least 1 code is required for both Current and Desired Activities for each category.

Housing Preferences:
Please describe the type of living situation you would most want to live in. If the answer to question a) is "Shared", then the question b) is required. If the answer to question c) is "Yes", then the addendum "When was this?" is required.

Page Six

Housing Preferences (cont'd.): Please check boxes to indicate which areas the person is willing to live in Philadelphia. At least 2 options are required.

Forms Requiring Signature

Authorization to Obtain, Use, and Disclose Health Information: This form is a requirement for disclosure of the information within the application so that it may be re- released to other services providers.

Medical Evaluations
The Medical Evaluation in this packet is used for the majority of Community Mental Health Residential Services. The exception is for those programs that are licensed as Personal Care Boarding Homes. If the person is being recommended for one of these programs, please complete the MA-51 in lieu of the DBH/IDS form. It must be signed by a licensed physician.

Psychiatric Evaluation
Please assure that all items are completed, including DSM codes for all diagnoses. Form must be signed by a licensed psychiatrist and dated.

Criminal Assessment Form
With any history of criminal court involvement, the Criminal History and Assessment Form must be completed in its entirety. If there is no history of Criminal Activity or Court Involvement, then the form must be filled in with the participant's name and signed by the submitting party.

DBHIDS INTEGRATED INTAKE

☐ Adult Case Management Only (Mental Health and/or Substance Use Disorders)

Referral Contact Person _____

Agency _____

Phone _____ EMAIL _____ Fax: _____

Please refer to Instructions to complete the application.

Participant's Name

Last _____

First _____ Middle _____

AKA _____

AKA Type _____

See Instructions for the AKA Types.

Gender ☐ Race _____

Ethnicity _____ Sexual Orientation ☐

Social Sec. # _____

Date of Birth: _____

Citizenship ☐ U.S. ☐ Permanent Alien

☐ Temporary ☐ Refugee ☐ Illegal Alien

English Speaking ☐ Yes ☐ No ☐ Limited

Address

_____

_____, P A _____

BSU Status

Participant BSU # _____ - _____

CIS # _____

Participant's Phone # _____

Emergency Contact Name: _____

Phone # _____

Insurance Carrier(s):

Primary: _____ Secondary: _____

Income source(s):

	Type	Amount
1	_____	$ _____
2	_____	$ _____

Name of Payee (if any):

Veteran Status: Are you a Veteran? ☐ Yes ☐ No Type of Discharge _____

If "Yes", are you eligible for VA Behavioral Health Benefits? ☐ Yes ☐ No

See Appendix A for Veteran Types of Discharge

Personal ID Forms Do you have government issued documents and/or ID? Please indicate below and clarify anything extraordinary.

Photo I.D. ☐ Yes ☐ No

Birth Certificate ☐ Yes ☐ No

Social Security Card ☐ Yes ☐ No

_____

Current Living Environment Provide Code: ____ *See Appendix B for Living Environment CODES*

a.) If person is presently **street** homeless, how many days _____

b.) # times **street** homeless in past 12 months _____

c.) # of different residences in past 12 months _____ (Number must be at least 1)

d.) # months at current residence: _____ (Number must be at least 1)

e.) What barriers exist for person remaining in current residence? _____

Participant Name _____ Date of Birth: _____

Current Hospitalization/Incarceration (H, I, or Either)	Psychiatric Assessment
Facility _____	ICD 10/DSM 5 CODE: DIAGNOSIS:
Admit Date ___/___/___	___. _____
Anticipated Discharge Date ___/___/___	___. _____
	_____
Contact Name: _____	_____
Contact Phone: _____	_____

Recent Hospitalization/Incarceration	Last 12 months	Last 6 months
# Crisis Response Center/Mobile Emergency Team Visits		
# Involuntary Commitments (302s)		
# Times Hospitalized - Psych (Include forensic inpatient)		
# Days Hospitalized - Psych (Include forensic inpatient)		
# Detox Episodes		
# Days in D&A Rehab (Residential)		
# Days in D&A Rehab (Out Patient)		
# Days Incarcerated		

Medication Regimen

a.) Has the person been prescribed medication? ☐ Yes ☐ No

b.) Is the person agreeable to taking medication? ☐ Yes ☐ No

c.) Does the person take medication that requires bloodwork? ☐ Yes ☐ No

(If so, which medication?) _____

d.) What resources does the person have to ensure medications are taken properly?
(Include human resources, finances, pharmacies, etc.)

_____

e.) **Medications Summary:**

Medication Name	Dose?	Taken as Prescribed?	How long Prescribed?

Participant Name _____ Date of Birth: _____

ADDITIONAL HEALTH INFORMATION: (Medications, Allergies, Health Issues, etc.)

_____

_____

Medical Issues/ Physical Disabilities

Do you have any medical or physical concerns? ☐ Yes ☐ No

_____ ☐ Episodic ☐ Chronic ☐ Acute Recent Treatment? ☐ Yes ☐ No

_____ ☐ Episodic ☐ Chronic ☐ Acute Recent Treatment? ☐ Yes ☐ No

_____ ☐ Episodic ☐ Chronic ☐ Acute Recent Treatment? ☐ Yes ☐ No

a.) Does the person use medication, devices or appliances for a physical disability? ☐ Yes ☐ No

b.) Does the condition impede the person's daily activity? ☐ Yes ☐ No

c.) Does the person cooperate with needed medical care? ☐ Yes ☐ No

d.) What assistance is needed to maintain health? _____
(Include human resources, finances, pharmacies, etc.)

Substance Use/Abuse Issues in last year? ☐ Yes ☐ No *(If yes, complete below)*

a.)

Substance Used	Amount	Frequency	Years of Continuous Use	Method

b.) Is person currently in D & A treatment? ☐ Yes ☐ No

c.) What is person's longest period of sobriety? _____

Note: If not in treatment, and use is current, then PCPC/ASAM must be completed and submitted.

d.) If NOT in treatment, is Participant interested in participating in D&A treatment? ☐ Yes ☐ No

e.) Is Participant interested in being connected with a D&A support group (which could include, but is not limited to 12-step programs)? ☐ Yes ☐ No

f.) If in a 12-Step program, does Participant have a Home Group? ☐ Yes ☐ No ☐ Desires connection

g.) If in a 12-Step program, does Participant have a Sponsor? ☐ Yes ☐ No ☐ Desires connection

Forensic System Involvement

a.) Has the person ever been convicted of a felony? ☐ Yes ☐ No

b.) Has the person ever been incarcerated? ☐ Yes ☐ No

c.) Is the person currently on probation or parole? ☐ Yes ☐ No

With any history of criminal court involvement, the Criminal History and Assessment Form must be completed.

From: _____ To: _____

Until: *(mm/dd/yyyy)* ___/___/___

Parole/Probation Officer Name _____ Parole/Probation Officer Phone _____

Participant Name _____ Date of Birth: _____

Relationship Status:

☐ Never Married ☐ Separated ☐ Partnered ☐ Widowed

☐ Married ☐ Divorced ☐ Common-Law*

* Effective Jan. 1, 2005 Common Law Marriage was abolished in PA. Prior are grandfathered into data.

Family Status: ☐ No Children ☐ Unknown

☐ Children, not pregnant ☐ Pregnant, no other children ☐ Pregnant, with additional children

Total Number of Children ☐ Male ☐ Female

Total Number of Dependent Children ☐ Male ☐ Female

If seeking permanent housing, will participant have custody of children? ☐ Yes ☐ No

Total Number of Custodial Children ☐ Male ☐ Female

Please provide any necessary clarification to Family Status and/or Child custody.

_____

Behavioral Risk Factors

(Choose one for each different area)

1=Not at all 2=Occasionally 3=Often 4=Very often

a.) Suicidal thoughts/behaviors 1☐ 2☐ 3☐ 4☐ _____ Date of last known instance (mm/dd/yyyy)

Circumstances _____

How much assistance must the person have in this area? _____

b.) Assaultive/Aggressive behaviors 1☐ 2☐ 3☐ 4☐ _____ Date of last known instance (mm/dd/yyyy)

Circumstances _____

How much assistance must the person have in this area? _____

c.) Fire setting behavior 1☐ 2☐ 3☐ 4☐ _____ Date of last known instance (mm/dd/yyyy)

Circumstances _____

How much assistance must the person have in this area? _____

d.) Aggressive or illegal sexual behavior 1☐ 2☐ 3☐ 4☐ _____ Date of last known instance (mm/dd/yyyy)

Circumstances _____

How much assistance must the person have in this area? _____

e.) Using the checkbox provided, describe person's ability to be aware of environmental risks.

1. Adequate 2. Needs Planning 3. Needs Intensive Support

1☐ 2☐ 3☐

Please explain.

_____

f.) Other identified behavioral risk factors (Optional): _____

_____

Participant Name _____ Date of Birth: _____

Meaningful Life Activities

General

a.) Activities of Daily Living	☐ 1. Adequate	☐ 2. Needs Planning	☐ 3. Needs Intensive Support
b.) Ability to use community resources	☐ 1. Adequate	☐ 2. Needs Planning	☐ 3. Needs Intensive Support
c.) Ability to access an activity	☐ 1. Adequate	☐ 2. Needs Planning	☐ 3. Needs Intensive Support
d.) Ability to plan & organize time	☐ 1. Adequate	☐ 2. Needs Planning	☐ 3. Needs Intensive Support

e.) In-home activities and interests: _____

f.) Out-of-home activities and interests: _____

Psychosocial *See Instructions Pages for Psychosocial CODES*

CURRENT Activities: Indicate all codes that apply ☐ ☐ ☐

DESIRED Activities: Indicate all codes that apply ☐ ☐ ☐

Educational/Vocational *See Instructions Pages for Ed/Voc CODES*

CURRENT Activities: Indicate all codes that apply ☐ ☐ ☐

DESIRED Activities: Indicate all codes that apply ☐ ☐ ☐

Social/Recreational/Leisure *See Instructions Pages for Social/Recreational CODES*

CURRENT Activities: Indicate all codes that apply ☐ ☐ ☐

DESIRED Activities: Indicate all codes that apply ☐ ☐ ☐

Current Participant Supports

a.) Does the person have any contact with family, friends, or community supports? ☐ Yes ☐ No

b.) How frequently does the person interact with family or friends? _____

c.) How long has the person been involved in the above relationships? _____

d.) Does the person indicate a desire or a willingness to engage in new relationships or activities? ☐ Yes ☐ No

Housing Preferences

Please describe the type of living situation you would most want to live in.

a.) Is this living situation by yourself or shared with someone? ☐ Alone ☐ Shared ☐ Either

b.) If shared, is there someone in mind you would want to live with? Who is that? _____

c.) Have you ever lived alone in an independent setting? ☐ Yes ☐ No When was this? _____

d.) Would you prefer to live in a group setting where meals and other supports are provided for you? ☐ Yes ☐ No

e.) Please add any additional information that is important to you. _____

_____

_____

Participant Name _____ Date of Birth: _____

Housing Preference, cont'd.

What area(s) of Philadelphia would you like to live in? Check a box to indicate interest in a section of Philadelphia. Please make at least 2 selections. (in parentheses are some of the neighborhoods in these areas).

- ☐ North Philly (Franklintown, Callowhill, Spring Garden, Poplar, Northern Liberties, Fairmount, Francisville, Brewerytown, Yorktown, Ludlow, North Central, Temple, Strawberry Mansion, Hartranft, Fairhill, Allegheny West, Tioga, Hunting Park, Nicetown)
- ☐ Kensington/Port Richmond (Fishtown, Kensington, Port Richmond, Juniata Park, Bridesburg)
- ☐ Northeast (Frankford, Tacony, Rhawnhurst, Mayfair, Fox Chase, Torresdale, Bustleton)
- ☐ Center City (Logan Circle, Chinatown, Old City, Rittenhouse Square, Washington Square)
- ☐ Southwest (SW Schuylkill, Bartram, Mount Moriah, Paschall, Elmwood Park/Clearview)
- ☐ West (University City, Powelton, Mantua, Belmont, Spruce Hill, Walnut Hill, Mill Creek, Parkside, Cedar Park, Cobbs Creek, Wynnefield, Overbrook, Carroll Park, Overbrook)
- ☐ South Philly (Grays Ferry, Bella Vista, Queen Village, Point Breeze, Pennsport, Tasker, Snyder, Girard Estate, Marconi Plaza, East Oregon)
- ☐ Northwest (Wissahickon, Manayunk, Roxborough, Andorra, East Falls, Germantown, Wister, Mt. Airy, Chestnut Hill, Feltonville, Olney, Logan, Fern Rock, Oak Lane, Cedarbrook, Ivy Hill)

If you are referred and approved for Permanent Supported Housing:

In order to live in an apartment and sign your own lease, you will have to be able to sign up for electric and gas in your own name (PECO and PGW).

There is a form you need to bring to a PECO office for them to fill out, and a form you need to bring to PGW for them to fill out.

☐ Applicant has past due payments as indicated below: (check each box that applies):

☐ PECO ☐ PHA/Section 8 ☐ Medical bills ☐ Car payments or other loans

☐ PGW ☐ Credit card(s) ☐ Student Loan

☐ Rent for non-PHA subsidized housing (e.g., HUD, Columbus Property Mgmt., 1260 HDC, etc.

☐ Rent or Mortgage owed to a private landlord, company or bank

☐ Other bills.debts (please describe): _____

Credit history:

In order to live in an apartment and sign your own lease, the landlord will probably check your credit. Please tell us what you know.

Y/N ☐ Applicant does know about their credit history

Y/N ☐ Applicant does have a credit history.

Y/N ☐ Applicant has good credit (paid promptly on all bills or debts, such as PECO, PGW, PHA, student loans, credit cards, rent or mortgage, hospital/doctor bills, and other bills and loans

Y/N ☐ Applicant has a Representative Payee (who handles financial matters, such as rent & bill payments)

Please share any additional information you think would help in determining supportive services:

_____

_____

_____

_____

CITY OF PHILADELPHIA
DEPARTMENT OF BEHAVIORAL HEALTH and INTELLECTUAL DISABILITY SERVICES (DBHIDS)
AUTHORIZATION TO OBTAIN, USE AND DISCLOSE HEALTH INFORMATION

Name:	SSN:
Current Location:	Contact Name: Phone #:
Address:	Date of Birth: SID/PP#:
Dates of Treatment:	

I have participated in the preparation of the attached application for residential services and I authorize the City of Philadelphia, Department of Behavioral Health to obtain, use or disclose the following health information:

☐ Application for Transitional Housing ☐ Application for Permanent Supported Housing

☐ Medical Evaluation (MA-51) ☐ Targeted Case Management

☐ Psychiatric Evaluation

☐ Criminal Assessment Form ☐ PCPC / ASAM

For the purpose ☐ Continuity of Care and Treatment Coordination

☐ Other: _____

I have been informed that I have the right to withdraw permission in writing at any time. I understand that my withdrawal of permission does not apply to information that was already released, used or shared. _____ (Initial)

This authorization is valid for one year from the date of signature.

I understand that this information may be re-released.

I understand that Targeted Case Management is a voluntary, time-limited service provided to assist me.

I have been informed of my right, subject to Section 7100.111.3 of the Pennsylvania Mental Health Procedures Act and subject to the Pennsylvania Drug and Alcohol Abuse Control Act, to inspect the material to be released.

This form has been fully explained and I understand its content.

Signature of Client 14 years or older:	Date:
Signature of Parent or Person Authorized in lieu of Parent:	Date:
Relationship to Client:	

Witnessed by:	Title:	Date:

Verbal Consent: If the client or parent is unable to provide a signature, the following two witnesses attest that the client or parent understood the nature of this release and freely gave verbal consent.

Verbal consent was freely given by _____

On _____ as witnessed by: _____

Signature of Witness:	
Title or Relationship:	Date:
Signature of Witness:	
Title or Relationship:	Date:

City of Philadelphia
Department of Behavioral Health/Mental Retardation Services
Criminal History and Needs Assessment

Client _____ Alias _____ DOB _____ Sex _____

SS # _____ PP# _____ Client's present location _____

Has the client been on a psychiatric unit during this incarceration? ☐ No ☐ Yes If "Yes", dates _____

Placement/Address prior to incarceration _____

Current Criminal Charges or Convictions:	Status: Preliminary Arraignment	Pre-Trial	Sentenced	Other	If Sentenced: Minimum DATE	Maximum DATE
_____	☐	☐	☐	☐	_____	_____
_____	☐	☐	☐	☐	_____	_____
_____	☐	☐	☐	☐	_____	_____

Does the client have any outstanding Court Orders? Yes ☐ No ☐ If so, a copy must accompany this referral.

Court stipulations/Conditions of Probation/Parole

_____

Past convictions (include Charge and Year of conviction)

_____ _____ _____

_____ _____ _____

Does the Client have a history of sexual convictions? ☐ Yes ☐ No ☐ Unknown If Yes, Dates _____

(SCIs only) Is Client registered vis a vis Megan's Law? ☐ Yes ☐ No ☐ Unknown

Circumstances of convictions (brief description)

_____

_____

Outstanding Detainers (Type/Jurisdiction)

_____

_____

Violation of Probation/Parole Detainers

Original conviction	Date adjudicated
_____	_____
_____	_____

Institutional Infractions during Incarceration _____

_____

Status			County	State	Officer	Phone	Exp Date
Probation	☐ Active	☐ Not active	_____	_____	_____	_____	_____
Parole	☐ Active	☐ Not active	_____	_____	_____	_____	_____

Criminal History and Needs Assessment

Special needs (e.g., wheelchair-bound, hearing- or vision-impaired, clothing) _____

_____

CLINICAL ISSUES: SUBSTANCE ABUSE and MENTAL HEALTH NEEDS

D&A treatment history: Details (dates, locations, circumstances) _____

_____

_____

Treatment during this incarceration _____

_____

_____

Client has expressed interest in post-release treatment ☐ No ☐ Yes

MH treatment history: Details (dates, locations, circumstances) _____

_____

_____

Treatment during this incarceration _____

_____

_____

Client has expressed interest in post-release treatment ☐ No ☐ Yes

Clinical Impressions (regarding Client's attitudes, compliance, gender issues, etc.) _____

_____

Active Restraining Order: ☐ No ☐ Yes Details: _____

_____

History of Homelessness ☐ No ☐ Yes Details: _____

_____

Other Referrals:

☐ FIR	☐ Pending	☐ Accepted	☐ Rejected	☐ IPP	☐ Pending	☐ Accepted	☐ Rejected
☐ FOCIS	☐ Pending	☐ Accepted	☐ Rejected	☐ TCM	☐ Pending	☐ Accepted	☐ Rejected
☐ TC	☐ Pending	☐ Accepted	☐ Rejected	☐ AAS	☐ Pending	☐ Accepted	☐ Rejected
☐ Other	_____						

Submitted by:

Name: _____ Phone: _____ Beeper: _____ Fax: _____

Signature: _____ Position: _____ Date: _____

PSYCHIATRIC EVALUATION

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY. PLEASE TYPE OR PRINT.

(Name plate if available)

NAME OF PERSON	D. O. B.	BSU #	CIS#

DIAGNOSES:	DSM-IV # *or* ICD9 #
AXIS I	
AXIS II	
AXIS III	
AXIS IV (specify stressors)	
AXIS V	

REASON FOR EVALUATION:

First Sx

First Treatment

First Hospitalization

Most Recent Hosp.

Current Sx

Current Source of Treatment

Physical Appearance: Grooming: **Nutrition:** **Abnormal movements:**

Alertness: **Orientation: Person -** **Place -** **Time –**

Concentration: **Memory:** **Speech:**

Mood: **Affect:** **Insight:** **Judgement:**

Delusions: **Hallucinations:**

Suicidality: (specify) **Homicidality: (specify)**

Changes (specify) in weight: **Appetite:** **Sleep:**

CURRENT MEDICATIONS: NAME	TARGET SYMPTOMS	DOSAGE	FREQUENCY

OTHER RECOMMENDED SERVICES:
☐ CASE MANAGEMENT ☐ DAY TREATMENT SERVICES ☐ OTHER: _____

OTHER INFORMATION *(e.g. environmental stimuli to be avoided, special consumer needs, etc.):*

PSYCHIATRIST'S NAME (print)	PSYCHIATRIST'S SIGNATURE	AGENCY	TELEPHONE#	DATE

MEDICAL EVALUATION

THIS FORM MUST BE COMPLETE AND PRINTED LEGIBLY TO BE PROCESSED.

NAME	D.O.B.	AGE	SEX

MEDICAL HISTORY (INCLUDE SURGICAL PROCEDURES, DRUG AND ALCOHOL TREATMENT, AND CURRENT MEDICAL PROBLEMS):
N.B. If diagnosed with diabetes, describe the person's ability to self-test and administer treatment.

HAVE YOU EVER USED THE FOLLOWING: CHECK HERE IF "NOT APPLICABLE" OR "NONE" ☐

	YES	CURRENT FREQUENCY OR DATE OF LAST USE		YES	CURRENT FREQUENCY OR DATE OF LAST USE
ALCOHOL			COCAINE		
MARIJUANA			OTHER DRUG(S) *(SPECIFY)*		
CIGARETTES					

FAMILY HISTORY: CHECK HERE IF "NOT APPLICABLE" OR "NONE" ☐

	YES	YOURSELF	FAMILY MEMBER *(RELATIONSHIP)*		YES	YOURSELF	FAMILY MEMBER *(RELATIONSHIP)*
DIABETES				CANCER			
HEART ATTACK				TUBERCULOSIS			
STROKE				BLOOD DISORDER			

CHECK ALL OF THE SYMPTOM(S) YOU'VE HAD DURING THE PAST YEAR: CHECK HERE IF "NOT APPLICABLE" OR "NONE" ☐

DURING THE PAST YEAR HAVE YOU EVER HAD THE FOLLOWING SYMPTOMS: *(CHECK THOSE THAT APPLY)*

☐ HEADACHES	☐ HEARING PROBLEMS	☐ PERSISTENT TIREDNESS	☐ HYPERTENSION
☐ DIZZINESS	☐ NOSE BLEEDS	☐ UNANTICIPATED WEIGHT GAIN OF MORE THAN 20 LBS.	
☐ BLOOD IN STOOLS	☐ PERSISTENT COUGH	☐ UNANTICIPATED WEIGHT LOSS OF MORE THAN 20 LBS.	
☐ VISION PROBLEMS	☐ A SORE THAT HAS NOT HEALED	☐ CHEST PAIN/TIGHTNESS	

MEDICAL EXAMINATION	HEIGHT	WEIGHT	BLOOD PRESSURE	TEMPERATURE	PULSE RATE	CBC

CHECK IF "ABNORMAL" OR IF MONITORING IS NEEDED CHECK HERE IF "NOT APPLICABLE" OR "NONE" ☐

EYES	☐ MUSCULOSKELETAL	☐ ABDOMEN	☐ NECK	☐ MOUTH
☐ OD/	☐ EARS	☐ SKIN	☐ NERVOUS SYSTEM	☐ VEINS
☐ OS/	☐ LUNGS	☐ NOSE	☐ THROAT	☐ ANAL-RECTAL
☐ BREAST	☐ GYN	☐ HEART	☐ ARTERIES	☐ LIVER
☐ EXTREMITIES	☐ LYMPH NODES	☐ HERNIA	☐ GENITALIA	☐ KIDNEYS

PHYSICAL DISABILITIES AND/OR LIMITATIONS

CURRENT MEDICATIONS (INCLUDE "OTC")

COMMUNICABLE DISEASE(S)

RECOMMENDED DIETARY LIMITATIONS (INDICATE WHY NONE IS RECOMMENDED IF CLIENT IS DIAGNOSED OBESE)

ALLERGIES

RECOMMENDATIONS FOR STAFF AT RESIDENTIAL FACILITY

PHYSICIAN'S NAME PRINTED	PHYSICIAN'S SIGNATURE	AGENCY	TELEPHONE#	DATE

Veteran Types of Discharge

Honorable

To receive an honorable discharge, a service member must have received a rating from good to excellent for their service. Service members who meet or exceed the required standards of duty performance and personal conduct, and who complete their tours of duty, normally receive honorable discharges. However, one need not complete a term of service to receive an honorable discharge, provided the reason for involuntary discharge is not due to misconduct. For instance, a person rendered physically or psychologically incapable of performing assigned duties will normally have their service characterized as honorable, regardless of whether the condition or disability was incurred in the line of duty, provided they otherwise exceeded standards. Similarly, a servicemember selected for involuntary discharge due to a Reduction in Force (RIF) will typically receive an honorable discharge, assuming his or her conduct while on active duty met or exceeded standards.

An honorable discharge can, on rare occasions, be granted to a former service member (whose service was characterized as less than honorable) as an act of clemency, should that person display exemplary post-service conduct and show evidence of outstanding post-service achievement in areas such as education and employment.[citation needed]

United States Marines must have a proficiency and conduct rating of 3.0/4.0 or higher to receive an honorable discharge.[1]

General

General discharges are given to service members whose performance is satisfactory but is marked by a considerable departure in duty performance and conduct expected of military members. Reasons for such a characterization of service vary, from medical discharges to misconduct, and are utilized by the unit commander as a means to correct unacceptable behavior prior to initiating discharge action (unless the reason is drug abuse, in which case discharge is mandatory). A commander must disclose the reasons for the discharge action in writing to the service member, and must explain reasons for recommending the service be characterized as General (Under Honorable Conditions). The service member is normally required to sign a statement acknowledging receipt and understanding of the notification of pending discharge memorandum. They are also advised of the right to seek counsel and present supporting statements.

In addition, service members are required to sign documents acknowledging that "substantial prejudice in civilian life" may be encountered under a general discharge.[2] Despite this, some personnel think because the discharge is described as general *under honorable conditions*, it is as good as or the same as an honorable discharge. Concerning VA disability and most other benefits that is true; however, a general discharge may preclude participation in the GI Bill, service on veteran's commissions, and other programs where a fully honorable discharge is required. However, one state, Illinois, prohibits discrimination against a veteran from housing or employment on the basis of unfavorable discharge from military service per the Human Rights Act of 1970.[3] It does not apply to dishonorably discharged veterans, as shown below.

Clemency Discharge

Clemency Discharge established by Presidential Proclamation 4313

By Presidential Proclamation 4313,[4] President Ford created a procedure for those military personnel who resisted against the Vietnam War to receive a Presidential Pardon and have their punitive discharges changed to a Clemency Discharge. It also provided a path for those who left the country to return. If the military personnel fulfilled certain requirements of alternative service, they would also receive a Certificate of Completion from the Selective Service System.

Other Than Honorable (OTH)

An OTH is the most severe form of administrative discharge. This type of discharge represents a serious departure from the conduct and performance expected of all military members. OTH discharges are typically given to service members convicted by a civilian court in which a sentence of confinement has been adjudged or in which the conduct leading to the conviction brings discredit upon the service. It can also be given as the result of certain civil hearings, like divorce for adultery. OTH discharges can be accepted in-lieu of court-martial proceedings at the service-member's request. Persons facing OTH are guaranteed, by the Uniform Code of Military Justice, the right to have their discharge heard by an administrative discharge board, which is similar to a court-martial but is not a public forum.

Recipients of OTH discharges are barred from reenlisting into any component of the Armed Forces (including the reserves), and are normally barred from joining the Army National Guard or Air National Guard, except under rare circumstances that require exception-to-policy waivers. As of September 2006, all 50 states had policies barring the reenlistment of OTH discharge recipients.

In addition, the majority of veterans' benefits are not available to individuals who receive an other than honorable conditions discharge, including the Montgomery GI Bill and (in most cases) VA healthcare benefits.

Bad Conduct (BCD)

Unlike an administrative discharge, a Bad Conduct Discharge (BCD) is a punitive discharge that can only be given by a court-martial (either Special or General) as punishment to an enlisted service-member. Bad conduct discharges are often preceded by a period of confinement in a military prison. The discharge itself is not executed until completion of both confinement and the appellate review process.

Virtually all veterans' benefits are forfeited by a Bad Conduct Discharge; BCD recipients are eligible for VA disability compensation, as the only discharge that forfeits all VA benefits in full is the Dishonorable Discharge.

Dishonorable

A dishonorable discharge (DD), like a BCD, is a punitive discharge rather than an administrative discharge. It can only be handed down to an enlisted member by a general court-martial. Dishonorable discharges are handed down for what the military considers the most reprehensible conduct. This type of discharge may be rendered only by conviction at a general court-martial for serious offenses (e.g., desertion, sexual assault, murder, etc.) that call for dishonorable discharge as part of the sentence.

With this characterization of service, all veterans' benefits are lost, regardless of any past honorable service. This type of discharge is regarded as shameful in the military. In many states a dishonorable discharge is deemed the equivalent of a felony conviction, with attendant loss of civil rights.[5] Additionally, US federal law prohibits ownership of firearms by those who have been discharged under dishonorable conditions[6] per the Gun Control Act of 1968.

Entry level separation (ELS)

Entry level separations, or uncharacterized discharge, are given to individuals who separate prior to completing 180 days of military service, or when discharge action was initiated prior to 180 days of service. This type of discharge does not attempt to characterize service as good or bad.

Living Environment Codes
1 - Living Alone Independently
2 - Living With Others (Largely Independent)
3 - CRR Minimum Supervision
4 - Personal Care Home
5 - Domiciliary Care or Foster Care
6 - Living With Others (Largely Dependent)
7 - Living Alone (Largely Dependent)
8 - Supported Living
9 - CRR Moderate Supervision
10 - CRR Maximum Supervision
11 - CRR Intensive Maximum Supervision
12 - Long Term Structured Residence
13 - MR-CLA
14 - General/VA Medical/Surgical Ward
15 - Nursing Home
16 - General/VA Psychiatric Ward
17 - Inpatient/Residential D/D Program
18 - Private Psychiatric Hospital
19 - Extended Acute Care Unit
20 - State Mental Hospital
21 - Single Room Occupancy Hotel
22 - Shelter/Mission/Progressive Demand/Safe Haven
23 - Criminal Detention (SCI, County Jail, Other)
24 - Other Institutional Setting (Not Specified Above)
25 - Homeless
26 - Other Community Setting (Not Specified Above)
27 - Children's Program
28 - OSH Transitional Housing Program
29 - Drug/Alcohol Recovery House

Psychosocial Activities Codes
1 - CIRC / Transformed Day Services
2 - Outpatient – Sees Outpatient Therapist (professional)
3 - Outpatient (IOP) – Intensive Outpatient Services
4 - Medication Clinic
5 - Clubhouse – MH + Vocational
6 - Addictions - Co-occurring/Drug & Alcohol Support (Program, Service or Mutual Support Group) e.g., NA, AA, Double Trouble, Friends Connection, etc.
7 - Addictions (non- D&A) Support (Program, Service or Mutual Support Group) e.g., Gambling, OCD, Over-eating, Sexual Addiction, etc.
8 - Mental Health Support: Non-Addictions, non-professional (Program, Service or Mutual Support Group e.g., OCD, BPD, Schizophrenia, etc.)
9 - Peer Support – Peer Counseling with individual Peer Specialist
10 - Peer Support – Peer Resource Center or Drop-in Center
11 - Warmline
12 - Other
13 - None of the Above

Educational/Vocational Codes
1 - Competitive Private Sector Employment (21+ hrs/wk)
2 - Attending College (7+ credit hours) or High School
3 - Remains at home to care for Dependents
4 - Competitive Private Sector Employment (20 or less hrs/wk)
5 - Retired (age 60+)
6 - Supported Employment (21+ hrs/wk)
7 - Supported Employment (20 or hess hrs/wk)
8 - Affirmative Industry Employment (21 + hrs/wk)
9 - Affirmative Industry Employment (20 or less hrs/wk)
10 - Transitional Employment (21+ hrs/wk)
11 - Transitional Employment (20 or less hrs/wk)
12 - Attending College (6 or less credit hrs)
13 - Actively Seeking Employment
14 - Attending Vocational School or Training
15 - Basic Academic Preparation (GED)
16 - Screening and Evaluation
17 - Sheltered Employment
18 - Ongoing Volunteer Work
19 - Sheltered Workshop
20 - Prevocational Training
21 - No Vocational or Educational Activity
22 - Actively seeking Volunteer work
23 - Basic Academic Preparation (Literacy or ESL Classes)
24 - Internship
25 - Other – Please explain on form

Social, Recreational, Leisure Activities Codes
SOLITARY ACTIVITIES
1 - Passive: (e.g., Cards, reading, television, listening to music, puzzles)
2 - Active/Creative: (e.g., Journaling, Story-writing, Drawing, Painting,
3 - Exploratory: (e.g., Pursuit of Hobbies or Other Interests)
4 - Playing an instrument, computer, cooking, scrapbooking, etc.)
5 - Relaxation & Stress Reduction – Exercises, Visualization, etc.
6 - Physical Exercise: on your own (e.g., running, yoga, Pilates, walking, weight training, etc.)
INTERACTIVE ACTIVITIES
(e.g., spending time together, movies, meals together, shared hobbies or interests, etc.)
7 - Social, Recreational, Leisure Activities with Significant Other(s)
8 - Social, Recreational, Leisure Activities with Friends
9 - Social, Recreational, Leisure Activities with Family
10 - Peer Resource Center or Drop-in Center
11 - Religious Affiliation
12 - Membership or Participation in Group Activities
13 - Physical Exercise: utilizing gym membership
14 - Team Sports Participation
15 - Other Please explain on form
16 - None of the Above

CITY OF PHILADELPHIA
DIVISION OF THE OFFICE OF HEALTH & OPPORTUNITY
Departmentof Behavioral Health &Intellectual disAbility Services

M E M O R A N D U M

TO: All Behavioral Health Service Providers

FROM: Arthur C. Evans, Ph.D., Commissioner

SUBJECT: Office of Mental Health Residential System Changes

DATE: August 20, 2012

The purpose of this correspondence is to provide you with an update on the pending changes in process for residential applications and resource information for individuals who may not meet the priority criteria to make such application.

As the City embarks on the implementation of a Permanent Supportive Housing (PSH) model, the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) is making its complementary transformation through the conversion of facility-based programs and congregate settings. DBHIDS will focus its development on an array of community based supportive services that are intended to meet the needs and preferences of the person in their new living arrangement within the community. We believe this system change will align us with the City's PSH model, promote long-term recovery, and bring the behavioral health system closer to fulfilling the objectives set forth in the Practice Guidelines' framework.

However, the positive course of this Systems Transition and Departmental Transformation will result in a significant reduction in the number of available facility-based and congregate beds. As such, it is necessary to make changes to the Central Intake process within the Office of Mental Health. The reduction in facility-based capacity has caused an increased number of applications to be deferred at the point of submission. Consequently, we are in the process of instituting the attached prescreening tool to assure that priority populations continue to be considered for the limited available beds. The system is no longer in a position to accept unrestricted numbers of applications, and will institute a prescreening process before an application for MH Housing will be approved for submission. Attached please find the Prescreening Protocol, along with a listing of Additional Services and Housing Resources.

Those persons previously referred to Community Support Network/Access to Alternative Services (CSN/AAS) who do not meet the priority population criteria would be provided review and supportive services through their Case Manager, Transformed Day Services, Certified Peer Services or Outpatient Services. In those cases where there

is no current connection to supportive services, we strongly encourage linkage with or application for services in order to assure further planning and coordination. The attached document includes a list of resources that may be available to assist individuals in continued treatment or supportive community services.

CBH Member Services or Clinical Care Managers can also be consulted to determine if returning to their previous place of residence is feasible and/or if additional supportive services such as case management, certified peer services, outpatient or transformed day services would be appropriate and available.

As we move forward with the residential transformation, it is our goal to reorganize the remaining residential services to a transitional rehabilitation and skill building service system. These residential services would be a short-term, intensive program that focuses on community integration and quick movement toward permanent supported housing.

These transformed programs would only serve those persons meeting criteria outlined in the attached checklist. Please use this as a guideline for determining if an application should be completed for transitional housing.

If you have any questions, please contact Gerard Devine, DBH Program Manager via email at gerard.devine@phila.gov, or at 215-546-0300.

DBHIDS
Community Support Network
Prescreening Protocol

DBHIDS Central Intake for Adult Mental Health Residential Services and Housing Support (Community Support Network) will no longer be accepting applications for housing and residential support without a predetermination review.

☐ **Person under review must meet ALL of the four criteria below:**

- ☐ S/He meets PA Adult Priority Group criteria for Serious Mental Illness. (PA Bulletin OMH 94-04)
- ☐ S/He is a Philadelphia County resident for a minimum of 6 months (exclusive of any institutional placement).
- ☐ S/He is at least 18 years old. Children's housing resources will first be explored for clients aged 18 to 21.
- ☐ Person's income is below $1000 per month unless there is a documented, extraordinary clinical or financial need.

☐ **Person under review must meet either Treatment History criteria or be experiencing at least one of the Co-existing Conditions.**

☐ **Treatment History**

- ☐ S/He is currently on Extended Acute Care (EAC) Unit, or
- ☐ S/He is currently on EAC Waiting List
- ☐ S/He is currently in a Long Term Structured Residence (LTSR)

☐ **Co-existing Conditions**

☐ **Psychoactive Substance Abuse Disorder**

Must first be coordinated with CBH (215-413-3100) or BHSI (215-546-1200) for treatment/rehab of addiction who will then coordinate referral to CSN if appropriate.

☐ **Homelessness*, when there has been**

- ☐ Documentation of Homeless Outreach Contacts (Outreach Coordination Ctr 215-232-1984) within past 90 days, or
- ☐ Admission to Safe Haven, or
- ☐ Multiple or Long-Term Shelter Admission See HUD Chronic Homeless Criteria

☐ **Those persons eligible for Release from Criminal Detention, who are monitored in**

- ☐ Criminal Mental Health Court, in coordination with the Specialized Clinical and Criminal Justice Unit (SCCJU), or
- ☐ Department of Corrections (DOC) referrals for persons who will be reaching maximum sentence in 12 months, in coordination with the SCCJU, or
- ☐ Philadelphia Prison System (PPS) Reentry Program Coordination, for persons reaching maximum sentence, or
- ☐ Other persons leaving long-term institutional settings, in coordination with the SCCJU.

* Homeless persons are those who are sleeping in shelters or in places not meant for human habitation, such as cars, parks, sidewalks or abandoned buildings.

Those persons previously referred to CSN/AAS would be provided review and supportive services through their Case Manager, Transformed Day Services, Certified Peer Services, or Outpatient Services. In the case where there is no current connection to supportive services, we strongly encourage linkage with or application for services if there is no one assigned, in order to assure further planning and coordination.

Please retain this prescreening tool for your use in determining whether a future applicant meets priority criteria.

For further questions, please contact us at: www.dbhids.org/contact-us/

DBHIDS
Community Support Network
Prescreening Protocol

Additional Services and Housing Resources

__CBH Member Services or Clinical Care Managers should be consulted on whether returning to their previous place of residence, or a similar living situation would be feasible with a Coordinated Community Support Services review.

If the person is in need of treatment, you can contact Member Services at 215-413-3100.

__CBH should be consulted for Substance Abuse Treatment if appropriate, or

__If uninsured contact BHSI at 215-546-1200 for treatment/rehab.

__OAS for Recovery House placement: 215-790-4974 or 215- 790-4979

__Housing & Support for MH and/or Substance Use Challenges: Joshua Achievement Center
215-765-2209
Contact: Pastor David Jones

__For persons who have a co-occurring serious mental illness and substance abuse disorder, you can also contact

__ Gaudenzia RINT RTFA Intake Coordinator at 215-223-9460, or

__ Girard RINT RTFA Intake Coordinator at 215-787-2213

__WWW.PHILADELPHIA.PA.NETWORKOFCARE.ORG Online resource for those seeking information about behavioral health and intellectual disability services.

__DBH continues to provide liaison with PCBH placement which will continue to be available. Please contact Brenda Blackwell-Sermon or Janice Porterfield at 215-599-2150 ext 3213 or 3214.

__PCA Resources access through the PCA Helpline at 215-765-9040, or at: WWW.PCACARES.ORG

__PAHousingSearch.com A free service to find affordable apartments.

__PHMC.ORG Maintains a resource guide to provide easy access to services and housing resources.

__www.cneneighborhood.org For information on the Office of Supported Housing (OSH) and information for individuals and families who are homeless.
For shelter admission for single men go to: Station House
2601 N. Broad Street (rear entrance near Lehigh)
Philadelphia, PA, 19123 (24 hours)
for women and families go to: Appletree Family Center
1430 Cherry Street
Philadelphia, PA, 1910[illegible] (7am to 3pm)

Please note OSH information may change. We will update asap, so please check the DBH Website at www.dbhids.org

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If the predetermination review indicates this person is appropriate for referral for Community Support Residential services, please complete the application available here. DBH Integrated Intake Form.xlsx

Please understand the provision of Behavioral Health residential services is not an entitlement under the State OMHSAS, or under Health Choices and resources are seriously limited.

Section B: Eligible Participants

Who is Considered Homeless?

The definition of who is homeless is found in section 103 of the McKinney-Vento Act and also referenced in the regulations at 24 CFR 583.5. Basically, a homeless person is someone who is living on the street or in an emergency shelter, or who would be living on the street or in an emergency shelter without SHP assistance. See special guidance on serving youth and persons who may be illegal aliens in the Special Guidance sections below.

A person is considered homeless only when he/she resides in one of the three places described below:

1. places not meant for human habitation, such as cars, parks, sidewalks, and abandoned buildings;
2. an emergency shelter; or
3. transitional housing for homeless persons.

If a person is in one of these three places, but most recently spent less than 30 days in a jail or institution, he/she qualifies as coming from one of these three categories.

In addition to the above three categories as noted in the 2005 NOFA and beyond, projects providing Transitional Housing including, Safe Havens, or Supportive Services Only projects may also serve populations meeting the following:

4. eviction within a week from a private dwelling unit and no subsequent residence has been identified and the person lacks the resources and support networks needed to obtain housing; or
5. discharge within a week from an institution in which the person has been a resident for 30 or more consecutive days and no subsequent residence has been identified and he/she lacks the resources and support networks needed to obtain housing.

Eligibility for New and Renewal Permanent Housing Projects

Beginning with the 2005 NOFA, persons assisted by ***new*** and ***renewal permanent housing projects*** must be homeless and come from:

1. places not meant for human habitation, such as cars, parks, sidewalks, and abandoned buildings;
2. an emergency shelter; or
3. transitional housing for homeless persons who originally came from the streets or emergency shelter.

It is HUD's intent to continue using these criteria in future NOFAs. Current grantees that apply for renewal grants should familiarize themselves with the homeless definition in the NOFA and be aware that HUD will expect them to apply these criteria to new program participants, not current participants. That is, the eligibility criteria above apply to the *screening process* as units become vacant. This does not mean that current residents are to be removed from housing if they entered on the basis of 5 listed above.

Who is Not Considered Homeless?

Persons who are not homeless may not receive assistance under SHP. Examples of people who are not homeless are those who are:

- In housing, even though they are paying an excessive amount for their housing, the housing is substandard and in need of repair, or the housing is crowded;
- Incarcerated;
- Living with relatives or friends;
- Living in a Board and Care, Adult Congregate Living Facility, or similar place;
- Being discharged from an institution which is required to provide or arrange housing upon release; or
- Utilizing Housing Choice Vouchers, except Katrina evacuees that received Katrina Disaster Housing Assistance Program (KDHAP) Housing Choice Vouchers.

Serving Chronically Homeless Individuals

Beginning with the 2004 NOFA, HUD has defined "chronically homeless" as an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least four (4) episodes of homelessness in the past three (3) years. In order to be considered chronically homeless, a person must have been sleeping in a place not meant for human habitation (e.g., living on the streets) and/or in an emergency homeless shelter.

As defined in the 2004-2007 NOFAs, a *disabling condition* is "a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions." A disabling condition limits an individual's ability to work or perform one or more activities of daily living.

An *episode of homelessness* is a separate, distinct, and sustained stay on the streets and/or in an emergency homeless shelter. A chronically homeless person must be unaccompanied and disabled during each episode.

To be defined as chronically homeless, a person must be sleeping in a place not meant for human habitation (e.g., living on the streets) or in emergency shelter at the time of the count or eligibility determination. The definition does not include those currently in transitional housing.

Special Guidance on Serving Persons Who May Be Illegal Aliens

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 imposed restrictions on eligibility for receipt of public benefits. Essentially, the law provides that illegal aliens *are not* to receive public benefits and specifies how the inquiry into a person's status is to be conducted. However, there is an exception to the law for community programs that are necessary for protection of life or safety. *SHP transitional housing* has been determined to be excepted because it provides short-term shelter or housing assistance, non-cash services at the community level and is not means-tested.

The exception does not apply to SHP permanent housing projects. For permanent housing projects, grantees that are governments are required to comply with the law and should contact their legal counsel for advice on how to comply. Grantees that are nonprofit charitable organizations are not required to, but may, verify an applicant's citizenship or immigration status before providing assistance. If a nonprofit elects to verify citizenship or immigration status, they must follow the procedures required by the Act and should consult with their legal counsel on how to comply.

How to Demonstrate Participant Eligibility at Application

When applying for SHP funds it is imperative that the *New Project Narrative* in the application demonstrates that the proposed population to be served is homeless. Applicants should indicate where the proposed population will be residing prior to acceptance in the project, and then clearly describe an outreach and engagement plan to bring the proposed population into the project.

How to Demonstrate Compliance during Project Implementation

Recipients must maintain adequate documentation to demonstrate the eligibility of persons served by SHP funds. Below are types of documentation that HUD will accept as adequate evidence of participant eligibility.

Persons Coming from an Emergency Shelter for Homeless Persons

The grantee or project sponsor must have written verification from the emergency shelter staff that the participant has been residing at an emergency shelter for homeless persons. The verification must be on agency letterhead, signed and dated.

Persons Coming from Transitional Housing for Homeless Persons

The grantee or project sponsor must have written verification from the transitional housing facility staff that the participant has been residing in the transitional housing. The verification must be on agency letterhead, signed and dated.

The grantee or project sponsor must also have written verification with a letter from the original agency verifying that the participant was living on the streets or in an emergency shelter prior to living in the transitional housing facility (see above for required documentation) or was discharged from an institution or evicted prior to living in the transitional housing facility and would have been homeless if not for the transitional housing (see below for required documentation).

Persons Living on the Street

For Supportive Services Only projects that provide services -- such as outreach, food, health care, and clothing -- to persons who reside on the streets, it may not be feasible to require the homeless persons to document that they reside on the street. It is sufficient for the outreach staff to certify that the persons served reside on the street. The outreach or service worker should sign and date a general certification verifying that services are going to homeless persons and indicating where the persons reside.

For all other SHP projects, the grantee or project sponsor should obtain information to verify that a participant is coming from the street. This may include names of other organizations or outreach workers who have assisted them in the recent past who might provide documentation. If you are unable to verify that the person is coming from the street, have the participant prepare or you prepare a written statement about the participant's previous living place and have the participant sign the statement and date it.

If an outreach worker or social service agency referred the participant to your agency, you must obtain written verification from the referring organization regarding where the person has been residing. This verification should be on agency letterhead, signed and dated.

Persons Coming from a Short-term Stay (up to 30 consecutive days) in an Institution

The grantee or project sponsor must have written verification on agency letterhead from the institution's staff that the participant has been residing in the institution for 30 days or less. The verification must be signed, dated, and on agency letterhead.

The grantee must also have written verification that the participant was residing on the street or in an emergency shelter prior to the short-term stay in the institution. See above for guidance.

Persons Being Evicted from a Private Dwelling

The grantee or project sponsor must have evidence of the formal eviction proceedings indicating that the participant was being evicted within the week before receiving SHP assistance.

If the person's family is evicting him/her, a statement describing the reason for eviction must be signed by the family member and dated. In cases where there is no formal eviction process, persons are considered evicted when they are forced out of the dwelling unit by circumstances beyond their control. In those instances, the grantee and project sponsor must obtain a signed and dated statement from the participant describing the situation. The grantee and project sponsor must make efforts to confirm that these circumstances are true and have written verification describing the efforts and attesting to their validity. The verification must be signed and dated.

The grantee and project sponsor must also have information on the income of the participant and what efforts were made to obtain housing and why, without the SHP assistance, the participant would be living on the street or in an emergency shelter.

Persons Being Discharged from a Longer Stay (>30 days) in an Institution (Including Prison)

The grantee or project sponsor must have evidence on agency letterhead from the institution's staff that the participant was in the facility more than 30 days and is being discharged within the week before receiving SHP assistance. The grantee and project sponsor must also have information on the income of the participant and what efforts were made to obtain housing, and why, without the SHP assistance, the participant would be living on the street or in an emergency shelter. If the person is being discharged from a prison and the prison is required to provide or arrange housing upon release, the person is not homeless.

Persons Fleeing Domestic Violence

The grantee or project sponsor must have written verification *from the participant* that he/she is fleeing a domestic violence situation. If the participant is unable to prepare the verification, the grantee/project sponsor can prepare a written statement about the participant's previous living situation and have the participant sign the statement and date it. Grantees and projects sponsors must also document lack of resources, lack of subsequent residence and lack of support network for persons fleeing domestic violence situations.

Youth

Youth are eligible to receive SHP assistance *only if* they meet the criteria listed above under *Who is Considered Homeless? and* they are not wards of the state under the state law where the youth resides. In addition to the documentation identified above, grantees and project sponsors serving youth must have written verification that the youth are not wards of the state.

Return to Top

How to Demonstrate Eligibility for the Permanent Housing Component

The permanent housing for persons with disabilities component may only accept homeless persons with a qualifying disability and their families. In addition to the types of evidence described above, organizations administering permanent housing funded projects must maintain evidence of disability status for their clients.

Disability Status

According to the McKinney-Vento Act (Section 11382), the term "disability" means:

A. A disability as defined in Section 223 of the Social Security Act (42 U.S.C. 423);

B. To be determined to have, pursuant to regulations issued by the Secretary, a physical, mental, or emotional impairment which:
   1. is expected to be of long-continued and indefinite duration,
   2. substantially impedes an individual's ability to live independently, and
   3. of a nature that could be improved by more suitable housing conditions (e.g., a substance abuse disorder *if* the person's impairment could be improved by more suitable housing conditions);

C. A developmental disability as defined in Section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000; or

D. The disease of acquired immunodeficiency syndrome (AIDS) or conditions arising from the etiologic agency for acquired immunodeficiency syndrome.

The grantee or project sponsor must have written verification from a state licensed qualified source that the person has such a disability. Qualified sources include medical services providers, certified substance abuse counselors, physicians or treating health care provider as stated in the Social Security Act (42 U.S.C. Section 423).

To verify disability under Section 223 of the Social Security Act, program staff can ask clients to sign a release form so that staff can request a verification of benefits from the Social Security Administration (SSA). Program staff can do this by mail or by calling the SSA information line at 1-800-772-1213 to verify the information verbally. A claim number should be included on all correspondence from SSA (award letters, benefit

statements, or verification letters). Claim numbers with the suffix *DI* show that the individual met the definition of disabled at Section 223 of the Social Security Act.

Documenting disability when clients do not receive Supplemental Security Income (SSI) involves getting a written statement from a qualified source that: (1) identifies the physical, mental or emotional impairment, why it is expected to be of long-continued or indefinite duration, how it impedes the individual's ability to live independently, and how the individual's ability to live independently could be improved by more suitable housing conditions; (2) identifies a developmental disability; or (3) identifies AIDS or related conditions.

Grantees should also reference Health Care for the Homeless' *Documenting Disability: Simple Strategies for Medical Providers* Guide for more information on documenting disability.

Section B: Frequently Asked Questions

1. **Can a project serve persons at risk of becoming homeless?**

   No. By law, only those persons who are homeless may be served by SHP. If your organization wants to serve persons at risk of becoming homeless, persons who are "doubled up," or persons who are "near homelessness," it would need to use another source. HUD administers the Emergency Shelter Grants (ESG) program that can fund homelessness prevention activities. A variety of other programs, such as the Housing Choice Voucher Program (HCV), Community Development Block Grant (CDBG) and HOME, serve low-income persons who may be at risk of becoming homeless due to poor housing conditions, overcrowding or other reasons. Contact your local HUD field office for more information on these and other programs.

2. **Can a project serve a person being discharged from a state mental health institution in a state that requires housing to be provided upon the person's release?**

   If your state has a policy requiring housing as part of a discharge plan, HUD does not consider those persons eligible for assistance since they will be placed in housing arranged by the state. Contact your state department of mental health or similar state agency for information on its discharge policy. If your state does not require housing as part of discharge planning, then those persons being discharged may be served as long as they meet the eligibility requirements. Please note that projects cannot be structured to target individuals being discharged from these institutions.

   As a condition for award, any governmental entity serving as an applicant must agree to develop and implement, to the maximum extent practicable and where appropriate, policies and protocols for the discharge of persons from publicly funded institutions or systems of care (such as health care facilities, foster care or other youth facilities, or correction programs and institutions) in order to prevent such discharge from immediately resulting in homelessness for such persons. This condition for award, required by law, is intended to emphasize that states and units of local government are primarily responsible for the care of these individuals, and to forestall attempts to use scarce McKinney-Vento Act funds to assist such persons in lieu of state and local resources.

3. **Are programs required to screen for sexual offenders?**

   No. There is no SHP requirement for programs to screen for sexual offenders. However, program staff should consider the population being served to determine whether screening for sexual offenders is appropriate.

4. **Can SHP funds be used to lease an apartment where a participant will live with a family member?**

   No. If the participant moves in with a family member, he/she no longer fits the definition of homeless. If a family is willing to house the participant, then the participant does not lack resources or support networks.

ABBREVIATIONS

AA/NA	Alcoholics Anonymous / Narcotics Anonymous
ACT	Assertive Community Treatment
ACL	Active Caseload List
AOD	Alcohol and Other Drugs
ATR	Access to Recovery Team
BCM	Blended Case Management
BHS	Behavioral Health System
BHSI	Behavioral Health Special Initiative
BHTEN	Behavioral Health Education & Training Network
BSU	Base Service Unit
CAC	Certified Addictions Counselor
CIRC	Community Integrated Recovery Center
CARES	Cross Agency Response for Effective Services
CBH	Community Behavioral Health
CEU	Continuing Education Units
CIF	Individual Identification Form
CM	Case Management
CQI	Continuous Quality Improvement
CODAAP	Coordinating Office of Drug and Alcohol Abuse Programs – now known as OAS
CPS	Certified Peer Specialist
CRC	Crisis Response Center
CSN	Consumer Support Network – (formally Access to Alternative Services – AAS)
CSP	Community Support Program
CST	Consumer Satisfaction Team
D&A	Drug and Alcohol
DBHMRS	Philadelphia Department of Behavioral Health and Mental Retardation Services
CARES	Cross Agency Response for Effective Services
EM	Environmental Matrix
EVS	Eligibility Verification System
F.A.C.E.	Factual And Clinical Elements (Sheet)

FIR	Forensic Intensive Recovery
FRN	Family Resource Network
ICM	Intensive Case Management
MA	Medical Assistance
MET	Mobile Emergency Team
MH	Mental Health
MIS	Management Information System
MISA	Mental Illness and Substance Abuse
NACM	National Association of Case Managers
OAS	Office of Addiction Services - (formally known as CODAAP)
OCC	Outreach Coordination Center
OMH	Office of Mental Health
OMHSAS	State of Pennsylvania Office of Mental Health and Substance Abuse Services
PARS	Prevention And Recovery Services
PCP	Primary Care Physician
PGP	Personal Goal Plan
RC	Resource Coordinator/Resource Coordination
RIM	Research and Information Management
RN	Registered Nurse
RRT	Rapid Response Team
SCCJU	Specialized Clinical and Criminal Justice Unit
SEPTA	Southeastern Pennsylvania Transportation Authority
SP	Significant Person/People (Family)
TA	Technical Assistance
TCM	(a)Targeted Case Management – All Mental Health Medicaid reimbursed case management services
	(b)Targeted Case Management – Acronym used for Blended Enhanced Case Management
TCMU	DBHMRS Target Case Management Unit
WMP	Wellness Management Plan (formally the Relapse Prevention Plan)
WRAP	Wellness Recovery Action Plan

GLOSSARY

Base Service Unit (BSU)	The Philadelphia BSU system is comprised of thirteen federally mandated community mental health centers located in specified catchment areas. It is a geographically based model intended to facilitate data collection and tracking of individuals based upon their area of residence. Historically, the BSU system has also been used as a 'safety net' where people with no insurance are directed and expected to receive services.
Community Behavioral Health (CBH)	is a private, non-profit corporation operated by the City of Philadelphia serving persons with mental illness and addictions. It is the largest behavioral health managed care organization in the country devoted to serving persons on Medicaid and the only one operated by a government body.
Concurrent Review	is a semi-annual process in which the service participant's need for continuing service is assessed. Continued authorization of Targeted Case Management services is determined by CBH through the DBHMRS-TCM Unit staff following review of information submitted by the agency Targeted Case Management Team (including the Individual Information Form and Personal Goal Plan).
Environmental Matrix - Adults	is a scale that evaluates the functional level of individuals on six identified activities and determines the need for case management services. The scale is used by OMH-TCM staff at the time of referral for case management services (provisional score). The scale is used by agency TCM staff 1) within 30 days of authorization to TCM services, 2) whenever there is a substantial change in the individual's life and 3) at the point of concurrent review.
Intensive Case Management (ICM)	as defined in Pennsylvania Code Title 55. Public Welfare DPW Chapter 5221. Current through 27 Pa.Bulletin 6168 (November 22, 1997) 5221.3 Definitions.
Medical Necessity Criteria	are factors used to determine a person's need for TCM services. These criteria are based on the person's mental health diagnosis, level of functioning, mental health treatment history, and the Environmental Matrix.
MH Residential	Mental Health Transitional Housing Programs that were previously considered "Residential Programs" have been the foundation of a psych-rehab service delivered in congregate or clustered apartment settings. Below are listed acronyms that have been used to describe these settings:
PDR Progressive Demand Residences	Provides minimal level of structure for persons being discharged from a hospital or are in urgent need of temporary housing.
RITA Rehabilitative Intensive Therapeutic Arrangement	Provides a comparatively structured setting. Persons referred may present greater behavioral challenges and generally need a higher client-to-staff ratio.
ICRR Intensive Community Rehabilitation Residence	
CRRX Max care CRR	
CRRM Mod care CRR	
RTFA Residential Treatment Facility - Adult	Also known as "RINT", provides greatest need for structure or the deepest commitment amongst those with co-occurring mental health and drug and alcohol abuse issues.
CLA Community Living Arrangement	
Psycho geriatric	Provides co-occurring MH/geriatric needs. These programs generally expect clients to be 55 to 60 years or older.

GLOSSARY

SHP	Supported Housing Program
	The apartments are frequently "clustered" in a single building. These programs commonly include HUD funding which requires that clients have a history of homelessness. When a client "graduates" from this program, he or she needs to find other housing arrangements (with assistance, as needed).
SIL	Supported Independent Living
	These apartments are commonly "scattered" throughout the city. When a client "graduates" from this program, he or she commonly remains in the apartment; the support team is simply withdrawn.
Natural Community Supports	are naturally occurring resources in the community that are available to all citizens in the community. Services and resources funded by the BHS are excluded by definition. Examples of natural community supports include religious organizations, recreation centers, family, and friends, other community members such as landlord, and neighbors, and educational programs.
Office of Addiction Services – OAS (formerly known as CODAAP)	is a component of the Behavioral Health System operated by the Philadelphia Department of Behavioral Health and Mental Retardation It has the responsibility of planning, funding, and monitoring substance abuse prevention, intervention, and treatment services within the City of Philadelphia.
Office of Mental Health	is a component of the Behavioral Health System operated by the Philadelphia Department of Behavioral Health and Intellectual Disabilities Services. It provides administrative, fiscal, program planning and monitoring for a comprehensive array of supplemental services for persons with mental illness such as residential and vocational services and Crisis Response Centers.
DBHMRS Targeted Case Management Unit (DBHMRS-TCM Unit)	is a unit that is dedicated to Targeted Case Management services and service provision for the Behavior Health System. The Unit is a primary support to the providers of TCM services for the Adult Mental Health individual and liaisons regularly with CBH and other OMH units to ensure quality of services to the BHS individual.
Personal Goal Plan (PGP)	is a strengths-based, individualized plan that serves as a roadmap for, and documents the provision of, TCM service. The PGP is an expression of the individual's needs and desires identified in his or her Strengths Assessment.
Blended Enhanced Case Management Model (TCM)	is an Intensive Case Management model in which the intensity of case management and frequency of individual contact vary in accordance with the individual's changing needs without altering the team of case managers. The pilot model also enhances delivery of service through the addition of a full-time consulting/treating psychiatrist, a nurse and a drug and alcohol specialist to the case management team.
Resource Coordination (RC)	as defined by Mental Health Bulletin (OMH-93-09) dated April 1, 1993 entitled Resource Coordination: Implementation.
Wellness Management Plan (WMP)	is an expansion of the Crisis Plan that includes relapse and crisis prevention interventions developed over time (the initial 90 days) with the person being served by TCM. The WMP may be a specialized Personal Goal Plan. The WMP identifies triggers, warning signs, special problems/needs and interventions/supports that have been developed with the person being served when they are in a period of stability. The plan is further developed as experience allows. The WMP may include (informal) Advance Directives.

DBHIDS INTEGRATED INTAKE--Completion Guide

Referral Contact Person*

Agency*

Phone* EMAIL.* Fax:

Key:
*Information is required to complete the field.
**Information is required if Yes is checked for a section

Please refer to Instructions to complete the application.

Participant's Name

Last*

First* Middle

AKA

AKA Type
See Instructions for the AKA Types.

Gender* Race*

Ethnicity* Sexual Orientation*

Social Sec. #*

Date of Birth:*

Citizenship* U.S. Permanent Alien

Temporary Refugee Illegal Alien

English Speaking* Yes No Limited

Address*

, P A

BSU Status

Participant BSU # -

CIS #

Participant's Phone #*

Emergency Contact Name:*

Phone #*

Insurance Carrier(s):*

Primary:* Secondary:*

Income source(s):*

	Type	Amount
1 *		$ Required if person has income
2 *		$

Name of Payee (if any):*

Veteran Status: Are you a Veteran?* Yes No Type of Discharge**

If "Yes", are you eligible for VA Behavioral Health Benefits?** Yes No

See Appendix A for Veteran Types of Discharge

Personal ID Forms Do you have government issued documents and/or ID? Please indicate below and clarify anything extraordinary.

Photo I.D.* Yes No

Birth Certificate* Yes No

Social Security Card* Yes No

Current Living Environment Provide Code:* *See Appendix B for Living Environment CODES*

a.) If person is presently **street** homeless, how many days

b.) # times **street** homeless in past 12 months

c.) # of different residences in past 12 months (Number must be at least 1)

d.) # months at current residence: (Number must be at least 1)

e.) What barriers exist for person remaining in current residence?

If Provide Code=25, then questions a) and b) are required

If Provide Code is any other number, then questions c), d), and e) are required.

Participant Name _____ Date of Birth: _____

Current Hospitalization/Incarceration (H, I, or Neither)*	Psychiatric Assessment
Facility Name** _____	ICD 9/DSM IV TR CODE: DIAGNOSIS:
Admit Date** ___/___/___	AXIS I* _____ _____
Anticipated Discharge Date** ___/___/___	AXIS II* _____ _____
If Hospital or Incarceration, all other info required	AXIS III* _____
Contact Name:** _____	AXIS IV* _____
Contact Phone:** _____	AXIS V* _____

Recent Hospitalization/Incarceration		Last 12 months*	Last 6 months*
# Crisis Response Center/Mobile Emergency Team Visits*	RIGHT:	1	0
# Involuntary Commitments (302s)*	RIGHT:	1	1
# Times Hospitalized - Psych (include forensic inpatient)*	RIGHT:	0	0
# Days Hospitalized - Psych (Include forensic inpatient)*	WRONG:	0	1
# Detox Episodes*	The Last 12 Months number must be	0	0
# Days in D&A Rehab (Residential)*	at least as large as the last	0	0
# Days in D&A Rehab (Out Patient)*	6 month numbers. See example.	0	0
# Days Incarcerated*		0	0

Medication Regimen

a.) Has the person been prescribed medication?* ☐ Yes ☐ No

b.) Is the person agreeable to taking medication?** ☐ Yes ☐ No

c.) Does the person take medication that requires bloodwork?** ☐ Yes ☐ No

(If so, which medication?) _____

d.) What resources does the person have to ensure medications are taken properly?**
(Include human resources, finances, pharmacies, etc.)

e.) Medications Summary:

Medication Name**	Dose?**	Taken as Prescribed?**	How long Prescribed?**

Participant Name _____ Date of Birth: _____

ADDITIONAL HEALTH INFORMATION: (Medications, Allergies, Health Issues, etc.)*

_____

_____

Medical Issues/ Physical Disabilities

Do you have any medical or physical concerns?* ☐ Yes ☐ No

**At least 1 condition is required if Yes checked for section above.	☐ Episodic**	☐ Chronic	☐ Acute	Recent Treatment?**	☐ Yes	☐ No
Each condition listed requires Eisodic/ Chronic/Acute Indicator and Recent Treatment?	☐ Episodic	☐ Chronic	☐ Acute	Recent Treatment?	☐ Yes	☐ No
	☐ Episodic	☐ Chronic	☐ Acute	Recent Treatment?	☐ Yes	☐ No

a.) Does the person use medication, devices or appliances for a physical disability?** ☐ Yes ☐ No

b.) Does the condition impede the person's daily activity?** ☐ Yes ☐ No

c.) Does the person cooperate with needed medical care?** ☐ Yes ☐ No

d.) What assistance is needed to maintain health?** _____
(Include human resources, finances, pharmacies, etc.)

Substance Use/Abuse Issues in last year?* ☐ Yes ☐ No *(If yes, complete below)*

a.)

Substance Used**	Amount**	Frequency**	Years of Continuous Use**	Method**

b.) Is person currently in D & A treatment?** ☐ Yes ☐ No

c.) What is person's longest period of sobriety?** _____

Note: If not in treatment, and use is current, then PCPC/ASAM must be completed and submitted.

d.) If NOT in treatment, is Participant interested in participating in D&A treatment?** ☐ Yes ☐ No

e.) Is Participant interested in being connected with a D&A support group** (which could include, but is not limited to 12-step programs)? ☐ Yes ☐ No

f.) If in a 12-Step program, does Participant have a Home Group? ** ☐ Yes ☐ No ☐ Desires connection

g.) If in a 12-Step program, does Participant have a Sponsor?** ☐ Yes ☐ No ☐ Desires connection

Forensic System Involvement

a.) Has the person ever been convicted of a felony?* ☐ Yes ☐ No

With any history of criminal court involvement, the Criminal History and Assessment Form must be completed.

b.) Has the person ever been incarcerated?** ☐ Yes ☐ No From:** _____ To:** _____

c.) Is the person currently on probation or parole?** ☐ Yes ☐ No Until: *(mm/dd/yyyy)*** ___/___/___

Parole/Probation Officer Name** _____ Parole/Probation Officer Phone** _____

Participant Name _____ Date of Birth: _____

Relationship Status:*

☐ Never Married ☐ Separated ☐ Partnered ☐ Widowed

☐ Married ☐ Divorced ☐ Common-Law^

^ Effective Jan. 1, 2005 Common Law Marriage was abolished in PA. Prior are grandfathered into data.

Family Status:* ☐ No Children ☐ Unknown

☐ Children, not pregnant ☐ Pregnant, no other children ☐ Pregnant, with additional children

Total Number of Children** ☐ Male ☐ Female

Total Number of Dependent Children** ☐ Male ☐ Female

If seeking permanent housing, will participant have custody of children?** ☐ Yes ☐ No

Total Number of Custodial Children** ☐ Male ☐ Female

Please provide any necessary clarification to Family Status and/or Child custody.

_____

Behavioral Risk Factors

(Choose one for each different area)

1=Not at all 2=Occasionally 3=Often 4=Very often

a.) Suicidal thoughts/behaviors* 1☐ 2☐ 3☐ 4☐ _____ Date of last known instance (mm/dd/yyyy)**

Circumstances** _____

How much assistance must the person have in this area?** _____

b.) Assaultive/Aggressive behaviors* 1☐ 2☐ 3☐ 4☐ _____ Date of last known instance (mm/dd/yyyy)**

Circumstances** _____

How much assistance must the person have in this area?** _____

c.) Fire setting behavior* 1☐ 2☐ 3☐ 4☐ _____ Date of last known instance (mm/dd/yyyy)**

Circumstances** _____

How much assistance must the person have in this area?** _____

d.) Aggressive or illegal sexual behavior* 1☐ 2☐ 3☐ 4☐ _____ Date of last known instance (mm/dd/yyyy)**

Circumstances** _____

How much assistance must the person have in this area?** _____

e.) Using the checkbox provided, describe person's ability to be aware of environmental risks.*

1. Adequate 2. Needs Planning 3. Needs Intensive Support

1☐ 2☐ 3☐

Please explain.** _____

f.) Other identified behavioral risk factors (Optional): _____

_____

Participant Name _____ Date of Birth: _____

Meaningful Life Activities

General

a.) Activities of Daily Living*	☐ 1. Adequate	☐ 2. Needs Planning	☐ 3. Needs Intensive Support
b.) Ability to use community resources*	☐ 1. Adequate	☐ 2. Needs Planning	☐ 3. Needs Intensive Support
c.) Ability to access an activity*	☐ 1. Adequate	☐ 2. Needs Planning	☐ 3. Needs Intensive Support
d.) Ability to plan & organize time*	☐ 1. Adequate	☐ 2. Needs Planning	☐ 3. Needs Intensive Support

e.) In-home activities and interests:* _____

f.) Out-of-home activities and interests:* _____

Psychosocial	*See Instructions Pages for Psychosocial CODES*			
CURRENT Activities: Indicate all codes that apply*	☐	☐	☐	At least 1 code per row required
DESIRED Activities: Indicate all codes that apply*	☐	☐	☐	
Educational/Vocational	*See Instructions Pages for Ed/Voc CODES*			
CURRENT Activities: Indicate all codes that apply*	☐	☐	☐	At least 1 code per row required
DESIRED Activities: Indicate all codes that apply*	☐	☐	☐	
Social/Recreational/Leisure	*See Instructions Pages for Social/Recreational CODES*			
CURRENT Activities: Indicate all codes that apply*	☐	☐	☐	At least 1 code per row required
DESIRED Activities: Indicate all codes that apply*	☐	☐	☐	

Current Participant Supports

a.) Does the person have any contact with family, friends, or community supports?* ☐ Yes ☐ No

b.) How frequently does the person interact with family or friends?* _____

c.) How long has the person been involved in the above relationships?* _____

d.) Does the person indicate a desire or a willingness to engage in new relationships or activities?* ☐ Yes ☐ No

Housing Preferences

Please describe the type of living situation you would most want to live in.

a.) Is this living situation by yourself or shared with someone?* ☐ Alone ☐ Shared ☐ Either

b.) If shared, is there someone in mind you would want to live with? Who is that?** _____

c.) Have you ever lived alone in an independent setting?* ☐ Yes ☐ No When was this?** _____

d.) Would you prefer to live in a group setting where meals and other supports are provided for you?* ☐ Yes ☐ No

e.) Please add any additional information that is important to you.* _____

_____

_____

Participant Name _____ Date of Birth: _____

Housing Preference, cont'd.

What area(s) of Philadelphia would you like to live in? Check a box to indicate interest in a section of Philadelphia. Please make at least 2 selections. (in parentheses are some of the neighborhoods in these areas).*

- ☐ North Philly (Franklintown, Callowhill, Spring Garden, Poplar, Northern Liberties, Fairmount, Francisville, Brewerytown, Yorktown, Ludlow, North Central, Temple, Strawberry Mansion, Hartranft, Fairhill, Allegheny West, Tioga, Hunting Park, Nicetown)
- ☐ Kensington/Port Richmond (Fishtown, Kensington, Port Richmond, Juniata Park, Bridesburg)
- ☐ Northeast (Frankford, Tacony, Rhawnhurst, Mayfair, Fox Chase, Torresdale, Bustleton)
- ☐ Center City (Logan Circle, Chinatown, Old City, Rittenhouse Square, Washington Square)
- ☐ Southwest (SW Schuylkill, Bartram, Mount Moriah, Paschall, Elmwood Park/Clearview)
- ☐ West (University City, Powelton, Mantua, Belmont, Spruce Hill, Walnut Hill, Mill Creek, Parkside, Cedar Park, Cobbs Creek, Wynnefield, Overbrook, Carroll Park, Overbrook)
- ☐ South Philly (Grays Ferry, Bella Vista, Queen Village, Point Breeze, Pennsport, Tasker, Snyder, Girard Estate, Marconi Plaza, East Oregon)
- ☐ Northwest (Wissahickon, Manayunk, Roxborough, Andorra, East Falls, Germantown, Wister, Mt. Airy, Chestnut Hill, Feltonville, Olney, Logan, Fern Rock, Oak Lane, Cedarbrook, Ivy Hill)

If you are referred and approved for Permanent Supported Housing:

In order to live in an apartment and sign your own lease, you will have to be able to sign up for electric and gas in your own name (PECO and PGW).

There is a form you need to bring to a PECO office for them to fill out, and a form you need to bring to PGW for them to fill out.

☐ Applicant has past due payments as indicated below: (check each box that applies):

☐ PECO ☐ PHA/Section 8 ☐ Medical bills ☐ Car payments or other loans

☐ PGW ☐ Credit card(s) ☐ Student Loan

☐ Rent for non-PHA subsidized housing (e.g., HUD, Columbus Property Mgmt., 1260 HDC, etc.

☐ Rent or Mortgage owed to a private landlord, company or bank

☐ Other bills.debts (please describe): _____

Credit history:

In order to live in an apartment and sign your own lease, the landlord will probably check your credit. Please tell us what you know.

Y/N ☐ Applicant does know about their credit history

Y/N ☐ Applicant does have a credit history.

Y/N ☐ Applicant has good credit (paid promptly on all bills or debts, such as PECO, PGW, PHA, student loans, credit cards, rent or mortgage, hospital/doctor bills, and other bills and loans

Y/N ☐ Applicant has a Representative Payee (who handles financial matters, such as rent & bill payments)

Please share any additional information you think would help in determining supportive services:

_____

_____

_____

_____