PERMANENT SUPPORTIVE HOUSING PROGRAM
INITIAL SERVICES REFERRAL

Applicant Name: _____ Date: _____

I. Referral Source

☐Self referred
Applicant Contact Phone Number _____

☐County / Agency referred
Agency / Hospital Name: _____
Contact person name: _____
Title / Position _____
Contact phone number: _____

II. Applicant Information

Current Address: _____
Street Address / Apt number

_____
City, State, Zip Code

Phone number: _____

Social Security Number: _____- ____- _____ Date of Birth: ___-___-___
Service Coordination Unit (SCU) Number _____ - _____ - _____

Are you currently on the Section 8 waiting list? Yes ____ No ____

Current source of income: ☐DPA ☐SSI ☐SSD ☐Wages ☐Other
Amount per month $_____

☐ No income currently, applying for: _____

If currently <u>not</u> residing in Allegheny County, please answer next two questions:

Have you ever lived in Allegheny County? When? For how long? _____
_____

What family members or other supports do you have in Allegheny County?
_____
_____

III. Current living arrangements:

☐ State Hospital _____
Admission Date _____ **(see Section IV)**

☐ Community Hospital _____
Admission Date _____ **(see Section IV)**

☐ LTSR _____
Admission Date _____

☐ CRR or Group Home _____
Admission Date _____

☐ PCBH _____
Admission Date _____

☐ Lives with family / friends

☐ Independent in community

☐ Other_____

IV. Hospital Course (ask your Social Worker to complete this section if currently in-patient)

Length of Current Admission _____
Reason for Admission _____

Have there been multiple admissions to the hospital over the last year?

☐ No ☐ Yes, How many? _____

Has there been a diversion meeting or has one been scheduled?

☐ No ☐ Yes, Date of meeting _____
What was the outcome? _____

Is the primary reason for considering the State Hospital due to a lack of appropriate housing or support? ☐ No ☐ Yes

Current Diagnoses:
Axis I _____
Axis II _____
Axis III _____

Where did the person live prior to admission? _____

V. Services History

Have you been diagnosed with a mental illness? ☐yes ☐ no
What is the diagnosis? _____

Are you currently receiving treatment for mental illness or using support services? ☐yes ☐no
If yes, who is the provider? _____

If moving back to Allegheny County, do you anticipate using mental health services in the area? ☐ yes ☐no
If yes, with what provider? _____

VI. Send to

Fax to: Clearinghouse Manager 267-548-3187

OR

Mail to:
Transitional Services, Inc
Attention: Clearinghouse Manager
806 West Street
Homestead, Pa 15120

(TSI office use only)

V. Services Being Requested

☐ Housing Support Services

☐ Bridge Subsidy

☐ Project Based Leasing

☐ Contingency Fund

Clearinghouse Manager: _____
Date received: _____
Date entered into Precision Care: _____
Sb/Jr 2007