Transitional Youth Housing Referral Form

Referral Guidelines

To refer a potential resident, complete the form and include the candidate’s signature as well as the signature of the Community Psychiatric Supportive Treatment (CPST) staff/Case Manager or individual making the referral (if applicable).

☐ Eligible candidates must be referred by a CPST or Case Manager and meet the following criteria:
  ☐ 18 – 25 years of age
  ☐ DSM-5 diagnosis (i.e. Mental Health and/or Substance Use Disorder)
  ☐ Stabilized behavioral health symptoms for no less than 2 months
  ☐ Independently maintain behavioral health treatment regimen, as programming is NOT treatment focused

☐ Candidates MUST be highly motivated to participate in the program. The items below are non-negotiable:
  ☐ Obtain employment or vocational skills with an overall goal to obtain permanent employment
  ☐ Complete educational endeavors if applicable
  ☐ Work with an assigned peer support specialist for skill building and development of self-sufficiency skills
  ☐ In the process of developing or maintain a daily schedule
  ☐ Obtain permanent/independent housing
  ☐ Upon obtaining employment or benefits, pay the monthly per diem rate for residence at the Transitional Youth Housing Program
  ☐ Maintain CPST/case management services while residing in the Transitional Youth Housing Program

☐ Exclusion criteria:
  ☐ Sex offenders
  ☐ Violent History
  ☐ Felony offenders will be considered on a case by case basis

☐ The Transitional Youth Housing Program is time limited (up to 12 months) and not considered permanent housing
Fax completed referral form to ADAMHS Board of Cuyahoga County, confidential FAX: 216-776-3069

Client Information

Date Form Completed: __________________________________________________________

Name: Last _____________________________ First __________________ MI_____________________

Current Address: _________________________________________ Phone _______________________

City/State: ______________________________________________ Zip __________________________

Date of Birth: _________________________   Age: ____________              Gender: M_______F______

Current Living Arrangement: _____________________________________________________________

Monthly Income: _________________________    Source of Income: ____________________________

Payee Name: _________________________________________ None____________________________

Legal Guardian Name: ____________________________     Phone______________________________

Reason client would like to move: _________________________________________________________

Referent Information

Name of Referent: ________________________________Title: ________________________________

Phone: _______________________________Email___________________________________________

Agency

Name/Address_________________________________________________________________________

City_________________________________State_______________________Zip__________________

Client History

Last Grade Completed/Where: _______________________Diploma/GED ________________________

Vocational Training: Yes _____ No _____ If yes, when/where_________________________________

Certificate received___________________________________________________________________

Employed: Yes_______ No _________ If yes, where ____________________________________________________________________________
History of Psychiatric Hospitalizations: None

If yes, when/reason _______________________

DSM-5 Diagnosis and Severity: ________________________________

Date of Psychological/Psychiatric Assessment: ________________________________

Date of Physical Health Assessment: ________________________________

Community Mental Health Provider: ________________________________

History of Intellectual/Developmental Disability: None

_____________________________________________________________________

_____________________________________________________________________

History of Health Problems: None

Ambulatory Problems ____ Diabetes____ Visual Impairment____ Hypertension____
Hearing Impairment____ Asthma____ Epilepsy____ Allergies____
Smoker____ Dental Problems____ Eating Disorder____ Incontinence____
Sleep Disorder____ Unable to Read____ Other____ (explain) __________________

Types of allergies: ________________________________

History of Substance Use: None

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<tr>
<th>Substance(s) of choice</th>
<th>Date of Last Use</th>
<th>Frequency</th>
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Periods of Sobriety: ________________________________

Substance Use Treatment: ________________________________

History of and/or Potential for Violence: None

Identify risk issues and behavioral management plan: ________________________________

History of Suicide: Yes ____ No ____

Identify risk issues: ________________________________

Number of suicide attempts: ______ last attempt: ________________________________

Criminal Justice Involvement: No ____
Currently on probation or parole: Yes _______ No _______

Name of Probation/Parole Officer: ________________________________________________________

What is the offence(s)? _________________________________________________________________

Current Medication: None_______

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<tr>
<th>Name of Medication/Purpose</th>
<th>Dosage/Frequency</th>
<th>Prescribed by:</th>
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Independent Living Skills

PLEASE RATE SKILLS USING THE FOLLOWING SCALE:

UKN – Insufficient Knowledge to Assess

N/A – Not Applicable

1 – Can Manage Independently

2 – Needs Occasional Instruction/Supervision/Direction

3 – Needs Regular but not Constant Instruction/Supervision/Direction

4 – Needs Continual Consistent Instruction/Supervision/Direction

Transportation _______ Concept of Money _________ Shopping/Cooking ________

Money Management _____ Laundry_____ Keeping Appointments ______

Getting up/Following Daily Routine _______ Taking Psychotropic/Prescribed Medication ______

Caring for and Coping with Physical/Medical Condition ______

Grooming and Hygiene ________ Ability to Follow Instructions ______

Setting Limits on Own Behavior _______ Ability to Assess and Verbalize Needs ______

Comments: ___________________________________________________________________________
Client Risk Factors (check all that apply)  

None________  
History of medication mismanagement/symptom _______  History of Arson ________  
Flight Risk ______  History of sexual acting out _____  History of homelessness ________  
History of impulsivity/impaired _______  History of eviction for fire hazards _______  
Routine refusal of medical treatment _______  History of symptom related unintentional fire _______  
History of eviction due to any reason from items above ______ (please indicate which item(s))  

SIGNATURES

Your signature on this document gives the Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board of Cuyahoga County permission to contact the CPST/Case Manager or other referent for additional information regarding this referral.

______________________________  ________________________________  
Client Signature               Date

______________________________  ________________________________  
Referring Agency Staff Signature>Title>               Date

Fax completed referral to ADAMHS Board of Cuyahoga County, Myra Henderson, LISW-S, Adult Behavioral Health Specialist II, FAX: 216-776-3069

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<tr>
<th>For Office use Only</th>
<th>Date Received</th>
<th>Date Reviewed</th>
<th>Referral Disposition</th>
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