Canal Commons
East House ESSHI Referral

Cover sheet

Applicant Name: _____ Date: _____

This applicant meets the preference criteria selected below:

____ Homeless/Recovering from Serious Mental Illness

____ Homeless/Recovering from Substance Use

____ Homeless/Chronic Homelessness

Eligibility Determination: *Service eligibility includes individuals who meet the criteria for homelessness and have a diagnosed SMI or SUD or individuals who meet the chronic homelessness definition.*

Attached eligibility documents: ☐ Homelessness verification – *required for all*
☐ Primary Mental Illness Diagnosis: _____
☐ Primary Substance Use Disorder Diagnosis: _____
☐ Secondary SUD/ SMI: Diagnosis: _____
☐ Secondary SUD/ SMI: Diagnosis: _____

To be considered for one of these unit's individuals must meet one of the following criteria for homelessness:

(1) be an un-domiciled person (whether alone or as a member of a family) who is unable to secure permanent and stable housing without special assistance. This includes those who are inappropriately housed in an institutional facility and can safely live in the community or

(2) be an adult or young adult reentering the community from incarceration or juvenile justice placement, who was released or discharged and who is without permanent or stable housing; or

(3) be a young adult between the ages of 18 and 25 years of age without a permanent residence, including those who left foster care within the prior five years and who were in foster care at or over age 16, and those aging out of a residential school for individuals with an intellectual or developmental disability.

Resident Name: _____ **Referral Date:** _____/ __/ _____

Resident Phone #: _____ **Date of birth:** _____/ __ / _____

Gender Identity: ☐ Male ☐ Female ☐ Other: _____

Current Address: _____

Social Security #: _____ **Medicaid/CIN #:**_____

Referral Agency: **Referred by:** _____

Phone #: _____ **Email:**_____

Preferred Language: _____ Interpreter needed for intake? ☐ Yes ☐ No

Emergency Contact:_____ **Relationship :**_____

Phone#:_____ **Email:** _____

Does the prospective resident have any therapy animals? ☐ Yes ☐ No

- If yes, does the prospective resident have documentation for the animal? ☐ *Yes* ☐ *No*

Does the prospective resident have active insurance?

☐ **Yes** ☐ **No - if no, is the application pending?** ☐ **Yes** ☐ **No**

Insurance provider: _____ **Subscriber ID #:** _____

Medical Doctor:

_____

Agency: _____

Phone #: _____

Other Clinical/Medical Provider:

_____

Agency: _____

Phone #: _____

Other Clinical/Medical Provider:

_____

Agency: _____

Phone #: _____

Other Clinical/Medical Provider:

_____

Agency: _____

Phone #: _____

Alerts: *please check all that apply*

:

☐History of Arson

☐Criminal History

☐Survivor of Domestic/intimate partner violence

☐Suicide attempt/ self-injury

If you selected any alerts, please list any relevant information:

_____

_____

_____

_____

_____

Chronic Health Conditions: _____

_____

_____

_____

Allergies: _____

_____

_____

_____

Please complete the following regarding the resident's ability and/or willingness to:

Manage their personal needs *(grooming, hygiene, laundry, cleaning, etc.)*: _____

Manage their own money: _____

Respond appropriately to emergency situations *(i.e. fire)*: _____

Use their own transportation, public transportation and other community resources: _____

Plan, shop and prepare meals: _____

Follow through with appointments independently: _____

Comply with medication regimen:

- Is resident self-medicating? ☐ Yes ☐ No - *If no, are supports in place to assist?* ☐ *Yes* ☐ *No*
- Filling their own prescriptions? ☐ Yes ☐ No - *If no, are supports in place to assist?* ☐ *Yes* ☐ *No*

Please describe the resident's previous:

Independent living experience: _____

Drug/alcohol history if relevant *(How long abusing? How long sober?)*:

Interpersonal skills/social support system *(including family)*:

Most recent hospitalization *(please include dates and causes)*:

Funding *(please check all sources of income recipient currently receives)*:

- ☐ SSI - $_____ *per month*
- ☐ SSD - $_____ *per month*
- ☐ SSP - $_____ *per month*
- ☐ DHS - $_____ *per month*
- ☐ SNAP - $_____ *per month*
- ☐ Alimony - $_____ *per month*
- ☐ Employment - $_____ *per month*
- ☐ Pension - $_____ *per month*
- ☐ Trust Fund - $_____ *per month*
- ☐ Other - $_____ *per month*

Medicare? ☐ Yes ☐ No

Medicaid? ☐ Yes ☐ No - *If yes, Medicaid #:* _____

Representative Payee? ☐ Yes ☐ No - *If yes, which agency:* _____

Assets *(please list all other assets)*: _____

Please be sure to include the following documents (if available) so there is no delay in processing your application.

☐ 1. Medical evaluation by a licensed provider (annual physical, etc.)

☐ 2. Hospital admission / discharge reports (dated within the past year)

This potential resident is medically and psychiatrically stabilized, does not need a higher level of care and is considered appropriate.

Signature of Referral Agent: _____ Date: ____ / ____ / _____

Signature Required

Print name and title: _____

Signature of Resident: Date: / /

S gnature Requ red

Print name: _____

Completed referrals can be submitted to:

Admissions@easthouse.org