

HOUSING AUTHORITY OF THE COUNTY OF SAN MATEO

REFERRAL FORM

For Supportive Housing Programs (S+C and SHP)

(Please complete all sections including signatures and appropriate attachments)

Client Name: _____ Referral Date: _____

Client Address (or name and number of person who can locate client): _____

Client Phone Number: _____ Alternate Phone Number: _____

SSN: _____ DOB: _____ Is the client a veteran? Yes No

Primary Contact Person for Client (e.g. their case manager): _____

Title: _____ Phone Number: _____

Referring Agency: _____

Referring Agency Address: _____

Name of Person Making Referral: _____

Title: _____ Phone Number: _____

Program: S+C
 SHP

If S+C, Indicate Unit Type: Tenant-Based (TRA)
 Sponsor-Based (SRA)

Special Needs:

Please check all that apply:

- a. Mental Illness
- b. Alcohol Abuse
- c. Drug Abuse
- d. HIV/AIDS and related diseases
- e. Developmental disability
- f. Physical disability
- g. Domestic violence
- h. Other (please specify) _____

Prior Living Situation:

Where did the client sleep in the week prior to being referred to the S+C/SHP program?

- a. Non-housing (street, park, car, bus station, etc.)
- b. Emergency shelter
- c. Transitional housing for homeless persons
- d. Psychiatric facility*
- e. Substance abuse treatment facility*
- f. Hospital*
- g. Jail/prison*
- h. Domestic violence situation
- i. Living with relatives/friends
- j. Rental housing
- k. Other (please specify) _____

**If the client is coming from one of these institutions but was there less than 30 days and was living in the street or emergency shelter prior to entering the treatment facility, please check a. or b., as appropriate.*

Is the client a chronically homeless person? Yes No

A chronically homeless person is an unaccompanied individual with a disabling condition who has either been continuously homeless for a year or has had at least 4 episodes of homelessness in the past 3 years.

Information on Additional Adults in Household

(If there are no other adults in the household, you do not have to complete this page)

If there will be any other adults living with the client (i.e. a spouse, partner, sibling, parent), please provide the following information for each adult. Use additional sheets if necessary. You do not need to provide information on attendants or children 18 or younger.

Name: _____

Relationship to Client: _____

SSN: _____ D.O.B.: _____ Is the client a veteran? Yes No

Chronically Homeless? Yes No

A chronically homeless person is an unaccompanied individual with a disabling condition who has either been continuously homeless for a year or has had at least 4 episodes of homelessness in the past 3 years.

Race:

Please check all that apply

- a. American Indian or Alaskan Native
- b. Asian
- c. Black or African-American
- d. Native Hawaiian or Other Pacific Islander
- e. White

Ethnicity:

- a. Hispanic or Latino
- b. Non-Hispanic or Non-Latino

Special Needs:

Please check all that apply:

- a. Mental Illness
- b. Alcohol Abuse
- c. Drug Abuse
- d. HIV/AIDS and related diseases
- e. Developmental disability
- f. Physical disability
- g. Domestic violence
- h. Other (please specify) _____

Prior Living Situation:

Where did the client sleep in the week prior to being referred to the S+C/SHP program?

- a. Non-housing (street, park, car, bus station, etc.)
- b. Emergency shelter
- c. Transitional housing for homeless persons
- d. *Psychiatric facility**
- e. *Substance abuse treatment facility**
- f. *Hospital**
- g. *Jail/prison**
- h. Domestic violence situation
- i. Living with relatives/friends
- j. Rental housing
- k. Other (please specify) _____

**If the client is coming from one of these institutions but was there less than 30 days and was living in the street or emergency shelter prior to entering the treatment facility, please check a. or b., as appropriate.*

**If the person is coming from one of these institutions but was there less than 30 days and was living in the street or emergency shelter prior to entering the treatment facility, please check a. or b., as appropriate.*

Housing History

Please list the last two places the client has lived and the circumstances for leaving:

1. Address: _____
Landlord/Operator _____ Phone #: _____
Dates of Occupancy: _____
Reason for Leaving: _____
2. Address: _____
Landlord/Operator _____ Phone #: _____
Dates of Occupancy: _____
Reason for Leaving: _____
3. Are there any patterns of behavior that interfere with community living? _____

4. What are this individual's major strengths for independent community living? _____

5. Please describe the client's homeless experience: when, where and for how long? _____

6. What other housing resources has this client applied for? _____

7. What was he or she not accepted or why didn't it work out? _____

Demographics and Mental Health History

Race: _____ Marital Status: _____ Primary Language: _____
Is the client a veteran? _____ If yes, does he or she receive VA services? _____
If yes, what kind? _____

Diagnosis:

Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: _____

Please include any and all drug and alcohol diagnoses on Axis I, whether bingeing or dependence. These diagnoses do not exclude your client from consideration for the S+C Program.

Rehab. Team: Please provide the name and phone number of the following:

*Please place an * next to the name of the Care Coordinator*

Conservator: _____
Case Manager: _____
Psychiatrist: _____
Therapist & Region _____
Parole/Probation Officer: _____
Vocational Counselor: _____

Current Psychiatric Medications and Dosage:

Prescribed By:

- 1. _____
- 2. _____

Other Medications and Dosage:

Prescribed By:

- 1. _____
- 2. _____
- 3. _____

Response to medications: Symptoms alleviated Symptoms Persistent

If persistent, please describe: _____

Does the client know how/remember to take medications as prescribed? Yes No

Is the client willing to take medications as prescribed? Yes No

Number of previous psychiatric hospitalizations: _____

Circumstances and date of most recent hospitalization: _____

Number of previous suicide attempts: _____ Date of most recent attempt: _____

Please describe: _____

Signs of Decompensation (please be as specific as possible): _____

Any incidents of violence towards self or others? Yes No Date of most recent: _____

If yes, please describe: _____

Any history of drug or alcohol abuse? Yes No If yes, types: _____

If yes, has there been treatment and where? _____

If yes, how long has the individual been clean and sober? _____

Are there random drug tests being done? Yes No

Financial Information

1. Gross Monthly Income: _____

2. Sources of Income (please check all that apply):

- GA SSI SDI VA Job Social Security Family Other

3. Is client under Rep Payee? Yes No If yes, who? _____

4. Is SSI Pending? Yes No If yes, approximate date: _____

5. Medical # _____ Medicare # _____ Other Insurance? _____

Other Persons Who Will Reside In Household

	Name	SSN	Gender	Relationship to Client	D.O.B.
1.					
2.					
3.					

Social Support

Sources of social support (e.g. friends, church group): _____

Current activities: _____

Employment Status

Please check one:

- Paid Employment (35+ hours/week)
- Paid Employment (less than 35 hours/week)
- Volunteer work (more than 35 hours/week)
- Volunteer work (less than 35 hours/week)
- Not in labor force
- Unemployed

HOUSING AUTHORITY OF THE COUNTY OF SAN MATEO

DISABILITY CERTIFICATION For Supportive Housing Programs (S+C and SHP)

Client Name: _____ SSN: _____

1. I certify that the above named client is disabled, because (*check one of the boxes below*):

- a. The client is receiving Supplemental Security Income (SSI) or Social Security Disability (SSDI) benefits or has been determined to be eligible for SSI or SSDI benefits.

If you check box a, you must attach a copy of the client's SSI or SSDI determination letter.

- b. The client is not receiving SSI or SSDI benefits but meets the following definition of disability:

“A person shall be considered to have a disability if such person (1) has a physical, mental, or emotional impairment which is expected to be of long-continued and indefinite duration; substantially impedes his or her ability to live independently; and is of such nature that such ability could be improved by more suitable housing conditions, or (2) has a developmental disability; or (3) has AIDS or conditions arising from its etiological effects.

If you check box b, the certification must be signed by a credentialed psychiatric or medical professional trained to make such a determination.

2. Please indicate the type of disability (*you may check more than one box*):

- SMI (Serious Mental Illness)
 CSA (Chronic Substance Abuse)
 SMI & CSA (Serious Mental Illness & Chronic Substance Abuse)
 PWA (Persons with AIDS or Related Diseases)
 PWOD (Persons with Other Disabilities)

WARNING: Section 1001 of Title 18 of the U.S. Code states that a person is guilty of a **felony** for knowingly and willingly making **false or fraudulent statements** to any department or agency of the United States.

I certify that the above information is correct to the best of my knowledge and that I have the appropriate documentation on file.

Signature

Date

Printed Name

Address

Title

City, State, Zip

Agency/Company Name

()

Phone Number

HOUSING AUTHORITY OF THE COUNTY OF SAN MATEO

264 Harbor Blvd., Bldg. A, Belmont, CA 94002-4017 • Fax: (650) 802-3372

HOMELESS CERTIFICATION For Supportive Housing Programs (S+C and SHP)

Please complete all sections including signatures and appropriate attachments

Client name _____, SSN _____ is currently:

(Check one)

Sleeping in an emergency shelter

If you check this box, the certification must be signed by a staff member of the emergency shelter in which the client is residing.

Sleeping in places not meant for human habitation (like cars, parks, sidewalks, etc.)

If you check this box, the certification must be signed by a staff member of an organization that is providing services to the person and can attest that he or she is homeless.

Living in transitional housing for homeless persons, having come from a shelter or place not meant for human habitation

If you check this box, the certification must be signed by a staff member of the transitional housing program in which the client is residing. The program must have documentation on file that the individual was homeless at the time he or she entered.

WARNING: Section 1001 of Title 18 of the U.S. Code states that a person is guilty of a **felony** for knowingly and willingly making **false or fraudulent statements** to any department or agency of the United States.

I certify that the above information is correct to the best of my knowledge and that I have the appropriate documentation on file.

Signature

Date

Printed Name

Address

Title

City, State, Zip

Agency/Company Name

()

Phone Number

**CONSENT FOR THE RELEASE OF CLIENT INFORMATION SUBJECT TO
THE LANTERMAN-PETRIS-SHORT ACT AND/OR FEDERAL ALCOHOL
AND DRUG REGULATIONS**

SHP/SPC PROGRAM APPLICATION

Name of Client: _____

Birth Date: ____/____/____ Mental Health # _____

I hereby authorize the members of the Shelter Plus Care/Supportive Housing Program Placement Committee, San Mateo County Mental Health Services Division and the local Housing Authority to discuss information and diagnoses obtained in the course of my Psychiatric and/or drug and alcohol treatment as it is relevant to my eligibility for the Shelter Plus Care/SHP Program(s).

I do/ I do not (circle one) hereby authorize the release of confidential psychiatric and/or drug and alcohol diagnoses and treatment information necessary to consider my Application for the Program. Release of the information to any person not specified is prohibited.

This consent shall be valid for a one-year period from the date it is signed, unless consent is withdrawn in writing.

Client Signature

Date

Signature of Referring Professional

Date

LPS Conservator (if applicable)

Date