Office of Alcoholism and Substance Abuse Services
Medicaid Re-Design Team Permanent Supportive Housing Referral Form

REFERRAL AGENCY INFORMATION

Date of Referral _____/_____/_____ **Referring Agency:** _____

Contact Name:_____ **Phone Number:** (_____)_____-_____

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BASIC APPLICANT INFORMATION

First Name:_____ **Last Name:** _____

Sex: _____ **Marital Status:** _____ **DOB:** _____/_____/_____ **SSN#:** _____-_____-_____

Current address: _____

City: _____ **State:** _____ **ZIP:** _____

County of Residence:_____ **Phone Number:** (_____)_____-_____

Marital Status: _____ **Number of Children:** _____ **Veteran:**❒ *Yes* ❒ *No*

Medicaid CIN #:_____ **Medicaid Managed Care Organization**: _____

Highest Grade Completed: _____ **How many months employed in the past year:** _____

Current Legal Status: _____

Name and phone number of PO*(if applicable)*: _____

Homelessness Assessment

1. **For the past 30 days, have you been living in an inpatient facility or housing that you own, rent, or stay in as part of a household?** ❒ *Yes* ❒ *No* ***If yes**, skip the next question*
2. **How would you describe your most common housing situation over the past 30 days?**
   ❒ *Emergency or temporary housing (shelter)* ❒ *On street or abandoned building* ❒ *Other*_____
3. **When was the last time that you lived in the same apartment or house for 3 months or longer?**
   ❒ *In the past 6 months* ❒ *6 months-1 year ago* ❒ *1-3 years ago* ❒ *More than 3 years ago* ❒ *Don't know*

Risk of Homelessness Assessment (if tenant currently homeless, skip this section)

4. **Are you pending eviction within 30 days (with court papers/marshal's notice as back-up)?** ❒ Yes ❒ No
5. **Are there issues with the building in which you live (condemned, foreclosure, loss of physical accommodations, building damage)?** ❒ Yes ❒ No
6. **Are you living in an extreme overcrowded situation?** ❒ Yes ❒ No
7. **Are you living in an environment that may jeopardize your recovery?** ❒ Yes ❒ No
8. **Have you experienced sudden and significant loss of income?** ❒ Yes ❒ No
9. **Are you pending discharge from an inpatient facility (rehab, residential facility, hospital) within 30 days?**
   ❒ Yes ❒ No
10. **Do you have a residence identified or resources and support networks that can help you obtain access to housing?** ❒ Yes ❒ No

Substance Use

11. How many drinks containing alcohol do you have on a typical day when you are drinking?
❒ *Never* ❒ *1-2* ❒ *2-3* ❒ *3-4* ❒ *5-6* ❒ *7-9* ❒ *10 or more*

12. In the past 12 months, which substance, if any, has caused you the most serious problems?
❒ *None* ❒ *Alcohol* ❒ *Heroin* ❒ *Cocaine* ❒ *Marijuana/cannabis*
❒ *Stimulants* ❒ *Sedatives* ❒ *Prescription Drugs*

13. What is the qualifying substance use disorder? (*include DSM code)* _____

Health Service Use

14. Have you been in inpatient hospitalization 1 or more times in past 12 months?
❒ Yes ❒No If yes, how many? _____

15. Have you had 4 or more emergency room visits in past 12 months?
❒ Yes ❒No If yes, how many? _____

See page 3 of this form for a definition of the 12 month period

16. If currently inpatient, pending discharge date: _____/_____/_____

17. If currently in other residential setting (i.e., community residence, supportive living, transitional housing), what was admission date: _____/_____/_____ pending discharge date: _____/_____/_____

**** Referring agency should provide any supporting documentation that is available to support the above episodes ****

Physical and Mental Health

18. Secondary Diagnosis(es) (include MH):_____

19. Medical conditions: _____

20. Medications: _____

21. Name of Physician/Clinic: _____

22. How many days have you experienced medical problems in the past 30? _____

23. How many days have you experienced mental health problems in the past 30? _____

Certification of Program Eligibility

To be completed by MRT Housing Provider

ADMISSION REQUIREMENTS FOR HOUSING PROGRAM (please check):

- ❒ Applicant has a primary diagnosis of a substance use disorder
- ❒ Applicant is actively enrolled in Medicaid
- ❒ Applicant has a history of 2 inpatient hospitalizations, **or** 5 emergency room visits within the past 12 months (*** or** 1 inpatient **and** 4 emergency room visits)
- ❒ Applicant is a single adult living alone
- ❒ Applicant has history of or is at risk of homelessness *(see page 4 of this form for definition of at risk of homelessness)*

The 12 month period is defined as 12 months prior to the date of referral to the MRT Housing Program OR 12 months prior to the date of entry to a community residence, supportive living or other transitional housing program.

Certify the applicant has had 2 or more inpatient hospitalizations in past 12 months (*see above):

List facilities and dates:

_____

_____

_____

OR

Certify the applicant has had 5 or more emergency room visits in past 12 months (*see above):

List facilities and dates:

_____

_____

_____

_____

_____

_____

Housing Provider Staff First and Last Name: _____

Date: _____/_____/_____

At Risk of Homelessness – Definition

At risk of homelessness includes persons who are in imminent danger of losing their permanent housing due to a sudden change in the building, the ownership or the life situation of the resident such as:

- The household has received an eviction notice;
- Tenants in a building have been informed that a public safety condemnation is imminent;
- Foreclosure proceedings are pending on the household's rental housing;
- The household is in an extreme overcrowded situation (the number of persons exceeds health and/or safety standards for the unit's size);
- The person is living in an environment that may jeopardize their recovery (i.e., active substance use; drug sales) and has no financial means of immediately securing alternative permanent housing;
- Sudden and significant loss of income for the household;
- Sudden loss of existing physical accommodations (i.e., elevator no longer works);
- The building has sustained significant damage such as fire, loss of water, loss of heat; and
- The individual is pending a discharge from an inpatient facility (i.e., rehab, residential facility, state hospital) AND has no subsequent residence identified and lacks the resources and support networks needed to obtain access to housing due to their substance use disorder.