ADAMHS BOARD OF CUYAHOGA COUNTY
ALCOHOL, DRUG ADDICTION & MENTAL HEALTH SERVICES

# 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_____**

| Substance(s) of choice | Date of Last Use | Frequency |
|---|---|---|
| | | |
| | | |
| | | |

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_____**

| Name of Medication/Purpose | Dosage/Frequency | Prescribed by: |
|---|---|---|
| | / | |
| | / | |
| | / | |
| | / | |
| | / | |

## 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***

| For Office use Only | Date Received | Date Reviewed | Referral Disposition |
|---|---|---|---|
| | | | |