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

Transitional Youth Housing Program

Referral Form

Program Description:

The Transitional Youth Housing Program (TYHP) is funded by the Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board of Cuyahoga County. The ADAMHS Board contracts with the Life Exchange Center, a peer run organization, to provide Peer Support Services.

TYHP was developed to support young adults, ages 18 - 25 years old, in gaining independent living skills and self-sufficiency. The provision of service is delivered through a non-clinical Peer Support model for recovery, which utilizes Certified Peer Supporters (CPS) who have a lived experience of mental health and/or substance use disorder and have sustained a recovery program. Staffing also includes a full-time program manager.

Each resident is assigned a CPS to work with one-on-one to develop a recovery plan, assist in learning specific skills to maintain their behavioral health symptoms, obtain/maintain employment, link to resources, manage finances, initiate higher educational goals if desired, and develop social supports in the community. The long-term goal (within 12-months) is to obtain permanent housing as defined by the individual resident.

Participation in the housing program is time-limited, up to 12 months and not be considered permanent housing. Residents with income or benefits will be required to pay a monthly per diem rate and security deposit for furnished one-bedroom apartment.

Location:

TYHP is located at 18464 Lakeshore Blvd., Cleveland, Ohio, 44119. Housing can be provided for up to five residents. The apartment building is not wheelchair accessible.

Eligibility:

Young adults must be highly motivated to participate in the program and meet the following criteria:

- Referred by a Community Psychiatric Supportive Treatment (CPST worker /Case Manager)
- CPST/Case Manager must be employed by ADAMHS Board contract agency and complete the referral form.
- CPST Supervisor must review and sign the referral form.
- 18 - 25 years of age and resident of Cuyahoga County.
- DSM-5 diagnosis (i.e., mental health and/or substance use disorder)
- Stabilized behavioral health symptoms for no less than three months
- Independently maintain their behavioral health treatment regimen such as take medication as prescribed, maintain personal hygiene.

Exclusion Criteria:

- Sex offenders
- Violent history
- Felony offenders will be considered on a case-by-case basis.

To Make a Referral:

- Case Manager complete Transitional Youth Housing Program Referral form.
- Email referral to: tyhpreferrals@adamhscc.org
- ADAMHS Board staff will contact Case Manager to schedule referral meeting.
- For additional information, contact Myra Henderson, Adult Behavioral Health Specialist II, at 216-479-3269.

BASIC DATA:

Client Name: _____ _____ _____
Last First MI

Current Address: _____ _____ _____ _____
Street City State Zip

Previous Address: _____ _____ _____ _____
Street City State Zip

Date of Birth: __/__/_____ SS#: _____ Phone #: _____

Client (GOSH)ID#: _____

Gender: ◯M ◯F

Ethnicity:
◯Caucasian ◯African American
◯Hispanic ◯Native American
◯Asian American ◯Other

Marital Status:
◯Married ◯Never Married
◯Widowed ◯Separated
◯Divorced

DEMOGRAPHIC DATA:

Monthly Income: _____
Income Source: _____
Medicaid/Medicare#: _____
Of Persons in Household:
Veteran: ◯Y ◯N
Education Level: _____
Education Type: _____

Current Location: _____
◯State Hospital ◯Private Hospital
◯Residential Facility ◯V.A. Hospital
◯Other _____

Previous Living Arrangement: _____
_____

Previous Residential Services: ◯Y ◯N If yes, describe: _____

VOCATIONAL/EMPLOYMENT HISORY: _____

DIAGNOSIS—DSM-V

Axis I _____/_____ Code(s):_____/_____

Axis II _____/_____ Code(s):_____/_____

Axis III _____

Axis IV (GAF) _____

ASAM LEVEL OF CARE (LOC), if applicable: _____

PSYCHIATRIC HOSPITALIZATION DATA:

Currently Hospitalized: ◯ Yes ◯ No
Most Recent Hospitalization Date: _____
Name of Hospital: _____
Date of most recent Psychiatric Assessment: _____
Anticipated Discharge Date: _____
# of Hospitalizations in the past 12 months: _____
# of days hospitalized in the past 12 months: _____

Identify Suicidal Ideations, Attempts, or self-harming behaviors: _____
_____
_____

CURRENT MEDICATIONS:

Name of Medication	Dose/Frequency	Prescribed By:
	/	
	/	
	/	
	/	
	/	

***Attach the list of medications if additional space is needed.**

Medication Compliance _____
Medication Allergies: ◯ Yes ◯ No
If Yes List: _____

SUBSTANCE USE DISORDER (SUD) HISTORY: ◯ Yes ◯ No

Describe past and current use: _____
_____
Substance(s) of Choice: _____
Patterns of Use: _____
Current Use: _____
Periods of Sobriety: _____
Previous Substance Use Disorder Treatment: _____
Willingness to enter SUD Treatment: _____

DEVELOPMENTAL DISABILITY (DD) SERVICES:

◯ Yes ◯ No
Describe any DD services the client has received or is currently receiving: _____
_____
Support Administrator _____Phone # (preferably cell) _____

PHYSICAL CONDITIONS: Please check all that apply:

Ambulatory Problems	☐	Asthma/COPD/ Respiratory	☐	Eating Disorder	☐	Gastrointestinal Problems	☐
Diabetes	☐	Hypertension	☐	Dental Problems	☐	Other	☐
Visual Impairment	☐	Epilepsy	☐	Incontinence	☐		
Hearing Impairment	☐	Allergies	☐	Sleep Disorder	☐		
High Cholesterol	☐	Cardio Vascular	☐	Tobacco User	☐		

Please Explain √ Conditions _____

_____

PREVIOUS/CURRENT CRIMINAL JUSTICE SYSTEM INVOLVEMENT: ○ Yes ○ No

Describe_____

_____

Court ordered/mandated to specialized residential services or 24 hr. supervision? ○ Yes ○ No

Explain: _____

Registered Sex Offender ○ Yes ○ No

Name of Parole/Probation Officer: _____Phone#: _____

HISTORY OF AND/OR POTENTIAL OF VIOLENCE: ○ Yes ○ No

If yes, please describe any interventions that have previously been effective:_____

_____

_____

INDEPENDENT LIVING SKILLS: Please Rate Skills Using Scale Below (circle):

UKN	Insufficient Information to Assess
N/A	Do Not Apply
1	Can Manage Independently
2	Needs Occasional Instruction/Supervision/Direction
3	Needs Regular-Not Constant Instruction/Supervision/Direction
4	Needs Continual-Consistent Instruction/Supervision/Direction

Skill Rating	**N/A**	**UNK**	**1**	**2**	**3**	**4**
Transportation	○	○	○	○	○	○
Keeping/Scheduling/ Appointments	○	○	○	○	○	○
Shopping	○	○	○	○	○	○
Cooking	○	○	○	○	○	○
Money Management	○	○	○	○	○	○
Laundry	○	○	○	○	○	○
Caring For Physical Conditions	○	○	○	○	○	○

Skill Rating	**N/A**	**UNK**	**1**	**2**	**3**	**4**
Cleaning	○	○	○	○	○	○
Following Daily Routine	○	○	○	○	○	○
Medication Compliance	○	○	○	○	○	○
Grooming/Hygiene	○	○	○	○	○	○
Setting Limits on Behaviors	○	○	○	○	○	○
Ability to Assess & Verbalize Needs	○	○	○	○	○	○

Skills Necessary for Transition to Less Restrictive Setting: _____

NARRATIVE SUMMARY:

Please describe in detail the necessity for temporary housing and peer support services:

_____

_____

_____

_____

_____

_____

SERVICE PROVIDER AGENCY INFORMATION:

Agency Name: _____ Office: _____Phone #_____

CPST Worker: _____ Phone # (Cell if Possible): _____

CPST Email: _____

CPST Supervisor: _____ Phone # (Cell if Possible): _____

CPST Supervisor Email: _____

PAYEE: ◯ Yes ◯ No

Name: _____ Phone # (Cell if Possible): _____

GUARDIAN: ◯ Yes ◯ No

Name: _____ Phone # (Cell if Possible): _____

OTHER SUPPORT PERSON(S): ◯ Yes ◯ No

Name: _____ Phone # (Cell if Possible): _____

SIGNATURES

Client Signature: _____ Date: _____

CPST Signature: _____ Date: _____

CPST Supervisor Signature: _____ Date: _____

Guardian Signature: _____ Date: _____
(If Applicable)

TYHP Referral MUST be emailed to tyhpreferrals@adamhscc.org