Central New York Services Shelter Plus Care & Supportive Living Program

Pre-Qualification/Referral Form

Date of Referral: _____

Referring Person & Agency: _____

Address: _____

Phone: _____ Fax_____ Email_____

Individual Referred: _____

Contact Phone Number: _____

Gender Identification: _____ DOB: ___/___/___

Social Security# ____-____-____ Race: _____

Does referred have legal primary residence of any dependents? ☐ Yes ☐ No How many? _____

Disability Status: Does referred have a documented disability?

☐ Substance Abuse ☐ Mental Health ☐ Domestic Violence

DSMIV Code: _____

Will referred household meet HUD "very low income" guidelines? **(HH income <$24,650 for 1 person, <$28,200 for 2 persons, <$31,700 for 3 persons, <$35,200 for 4 persons)** ☐ Yes ☐ No

Is referred currently enrolled in mental health and/or substance abuse services?

	Service Provider	**Length of Treatment**	**Compliance w/treatment**
Mental Health Services			Yes or No
Substance Abuse Services			Yes or No

What is your impression of the referred person's ability to function independently> what are their immediate needs? Are there any other comments or concerns?

_____

_____

_____

_____

Clients Emergency Contact Information:

Name: _____Phone #:_____Relationship:_____

Participant Eligibility Worksheet

Participant Name: _____

Type of Homelessness Documentation (Check the appropriate type of documentation used to verify homelessness and attach it to this worksheet. Maintain these forms in the participant file.)

Homeless Status	Type of Documentation	Documentation Attached
Persons living on the street	A signed and dated general certification from an outreach worker verifying that the services are going to homeless persons, and indicates where the persons served reside.	☐
Persons coming from living on the street (and into a place meant for human habitation)	Staff should provide written information obtained from third party regarding the participant's whereabouts, and, then sign and date the statement.	☐
Person coming from an emergency shelter for homeless persons	Written referral from the agency	☐
Person coming from transitional housing for homeless persons	Written verifications to include program residency and homeless status prior to program entry.	☐
Person from a short-term stay in an institution who previously resided on the street or in an emergency shelter	Written verification from the institution's staff that the participant has been residing in the institution for less than 90 days; and information on the previous living situation.	☐
Persons being discharged from a longer stay in an institution	Written verification from the institution of discharge within one week of receiving homeless assistance AND documentation of income, efforts to obtain housing, and why person would be homeless without assistance.	☐
Persons fleeing domestic violence	Written, signed, and dated verification from the participant.	☐

Staff Member: _____ Date: _____

Participant: I verify this information is true and accurate. I confirm that I have been or am about to be homeless.

Signature of Participant: _____ Date: _____

Client Disability: Eligibility Documentation

Participant Name: _____

Check the current status and attach the appropriate documentation to verify disability

Disabling Condition	Type of Documentation	Documentation Attached
Any	Income from US Social Security Administration based on disability: SSI/SSD, Statement or copy of check.	☐
Serious Mental Illness	Documentation (diagnosis) from a credentialed psychiatric professional (i.e., psych/social signed and dated.	☐
Chronic Substance Abuse -Must be documented history and must impeded ability to live independently	Documentation and diagnosis from a credentialed psychiatric or medical professional trained to make such determination.	☐
HIV+/AIDS or AIDS related disease -Must impede ability to live independently	Documentation including diagnosis from a credentialed medical professional that is trained to make such determination	☐
Physical Disability -Must be long-term and of indefinite duration; substantially impedes ability to live independently	Documentation including diagnosis from a credentialed medical professional.	☐
Developmental Disability -Severe and chronic. Attributable to mental or physical impairment; manifested before 22yrs. Old and results in substantial functional limitations.	Documentation including diagnosis from a credentialed psychiatric or medical professional that is trained to make such a determination.	☐
Other Mental or Emotional Impairments - Requires combination or long-term care/treatment	Documentation including diagnosis from a credentialed psychiatric or medical professional that is trained to make such a determination.	☐
Other: (Explain)		☐
Chronic Homelessness -Single, disabled adult + Continuously homeless for 1 year or 4 or more episodes of homelessness in the past 3 years (streets/shelters)	Written verification from outreach workers, shelters and brief, written statement regarding previous shelter/street stays (dates, locations) and disability documentation.	☐

Staff Member: _____ Date: _____

Participant: I verify this information is true and accurate. I confirm that I have been determined disabled.

Signature of Participant: _____ Date: _____

Checklist of Items Needed for a Complete Referral

Type of Documentation	Documentation Attached
A complete 3 page referral packet **(this must be completed by a community provider, no self-referrals will be accepted).**	☐
Homelessness Documentation **(pg. 2 of referral packet)** signed and dated by staff member and referent.	☐
Disability Documentation **(pg. 3 of referral packet)** signed and dated by staff member and referent.	☐
Proof of Income (i.e. Public Assistance Budget or proof of application for Public Assistance or 1 month of current and consecutive pay stubs from wages earned or the current year's SSI/SSDI award letter)	☐
Letter from current treatment provider with Mental Health and/or Substance Abuse diagnosis code and compliance with treatment **(must be on company letterhead)**	☐
Letter stating status of homelessness from current residence (i.e. emergency shelter) **(must be on company letterhead)**	☐

Central New York Services

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