Transitional Living Services of Northern New York
482 Black River Parkway
WATERTOWN, NEW YORK 13601
(315)782-1777
FAX (315)785-8628
E-mail: services@tlsnny.com

SUPPORTED HOUSING PROGRAM ELIGIBILITY CRITERIA

The purpose of the Supported Housing Program is to provide one time rental assistance, security deposits, and/or household goods to individuals who are capable of living on their own, in the community, with minimal supports.

Please fill in the individual Psychiatric Diagnosis and Code in the space provided and check all applicable criteria.

Client MUST meet criteria A:

(***Please note**: Autism and Mental Retardation ARE NOT diagnoses that meet this criteria*)

_____A. Designated Mental Illness Diagnosis: The individual must be 18 years of age and currently meets the criteria for a DSM-IV psychiatric diagnosis other than alcohol or drug disorders, organic brain syndromes, developmental disabilities, or personality disorders. ICD-9-CM categories and codes that do not have an equivalent in DSM-IV are also NOT included as designated mental illness diagnoses.

Diagnosis:_____ Code:_____

Client must ALSO meet one or more of the following:

_____B. SSI or SSDI Enrollment due to Mental Illness: The individual is currently enrolled in SSI or SSDI due to a designated mental illness.

_____C. Extended Impairment in Functioning due to Mental Illness: The individual must meet 1 or 2 below:

1. The individual must be functionally disabled due to mental illness for at least the past twelve months either continuously or intermittently in at least two of the following areas: Self Care; Social Functioning; Activities of Daily Living; Ability to Concentrate
2. The individual has met the criteria for ratings of 50 or less on the Global Assessment of Functioning Scale due to a designated mental illness over the past twelve months on a continuous or intermittent basis.

_____D. Reliance on Psychiatric Treatment, Rehabilitation and Supports: A documented history shows the individual at some point prior, met the threshold for C (above), but symptoms and/or functioning problems are currently attenuated by medication or psychiatric rehabilitation and supports.

I verify that this individual has a severe and persistent mental illness and meets the eligibility criteria.

Name: _____

DOB: _____

Signature of Registered Nurse, LMSW, LCSW, LMHC, Psychiatrist, or Psychologist

License Number

_____ _____

Please Print Name

Date

_____ _____