



Transitional Living Services of Northern New York

482 Black River Parkway
WATERTOWN, NEW YORK 13601
(315)782-1777
FAX (315)785-8628

SUPPORTED HOUSING PROGRAM:

Supported housing enables individuals to live more independently in the community. Supported housing recipients must be able to live in the community with a minimum of staff intervention. Supported housing can provide start-up costs including security deposit, rent, and/or necessary furniture or household items.

FOR SUPPORTED HOUSING REFERRALS: Please complete the Adult Referral Form. An eligibility form signed by a qualified treatment provider must be attached. If requesting assistance with rent or security deposit a landlord statement will need to be completed and signed by the landlord

Date: _____ Referring Agent: _____
Title: _____
Agency: _____
Telephone#: _____

Referring to:
Supported Housing

Identifying Data:

NAME: _____
ALIAS/MAIDEN: _____
SEX: Male Female
STREET: _____
CITY: _____
ZIP: _____
SS NUMBER: _____
DOB: _____
TELEPHONE #: _____
MARITAL STATUS: S M W D Separated
INSURANCE TYPE: _____
POLICY NUMBER: _____
ISSUING COUNTY: _____
VETERAN: Yes No

Please indicate if applicable:
<input type="checkbox"/> PC Long Stay
<input type="checkbox"/> MRT
<input type="checkbox"/> RCE

Emergency Contact:

NAME: _____
RELATIONSHIP: _____
STREET: _____
CITY: _____
NEAREST RELATIVE: _____
ADVANCED DIRECTIVES: Yes No
AGENT: _____

Psychiatric Information:

Psychiatric Providers:

Therapist: _____

Clinic: _____

Psychiatrist: _____

Clinic: _____

Diagnosis:

AXIS I: _____

CODE: _____

AXIS I: _____

CODE: _____

AXIS II: _____

CODE: _____

AXIS III: _____

CODE: _____

AVIS V: _____ Current GAF: _____

CODE: _____

Current Medications:

Psych Medical Name: _____ Dosage: _____

Psych Medical Name: _____ Dosage: _____

Psych Medical Name: _____ Dosage: _____

Psych Medical Name: _____ Dosage: _____

Psych Medical Name: _____ Dosage: _____

Psych Medical Name: _____ Dosage: _____

Medical Information:

Physical Exam Yes No Comments: _____

Mantoux Test (within 1 yr.) PPD Yes No Comments: _____

Sleep Apnea Yes No Comments: _____

Cardiac/COPD Problems Yes No Comments: _____

If yes, do you require oxygen/breathing machine? Yes No

Diabetes Yes No Comments: _____

If yes, are you required to test blood sugar? Yes No

If yes, are you independent with management? Yes No

Seizure Disorder Yes No Date of last incident: _____

Allergies Yes No Comments: _____

Special Diet Yes No Comments: _____

Limited Ambulation Yes No Comments: _____

Any restrictions of activities Yes No Comments: _____

Medical Providers:

Medical Doctor: _____ Practice: _____

Dentist: _____ Practice: _____

Specialist: _____ Practice: _____

Other: _____ Practice: _____

Specific Problems:

- Resistant to treatment and/or medications Yes No Comments: _____
- Multiple psychiatric admissions Yes No Comments: _____
- Long term psychiatric admission (over 1 year) Yes No Comments: _____
- MICA Yes No Comments: _____
 - Alcohol abuse
 - Drug abuse
 - Substance abuse treatment
- Suicidal Ideations Yes No Comments: _____
- Suicidal Attempts Yes No Comments: _____
- Trauma Yes No Comments: _____
- Sexual Misconduct Yes No Comments: _____
- Sexual Offender Yes No Comments: _____
- Property Damage Yes No Comments: _____
- History of Violence Yes No Comments: _____
- Criminal History Yes No Probation/Parole Officer: _____
- Arson Yes No Comments: _____

Management Problems:

- Daily living skills (cooking, chores, budgeting, etc) Yes No Comments: _____
- Nighttime agitation Yes No Comments: _____
- Temper outbursts Yes No Comments: _____
- Incontinence Yes No Comments: _____
- Elopement Yes No Comments: _____
- Smokes safely Yes No Comments: _____
- Frequent crisis contacts (ER, police, etc) Yes No Comments: _____
- Social or Family Yes No Comments: _____
- Aware of basic fire safety Yes No Comments: _____
- Are you able to self preserve? Yes No Comments: _____

Social Data:

- Highest level of education: _____
 - ACCES-VR Involvement: Yes No Comments: _____
 - Employment training history: _____
 - Social/Day programs: _____
 - History of homelessness: _____
 - Previous supervised living placements: _____
 - Describe previous living environment the individual cannot return to along with specific problems/reasons: _____
-

Financial Information:

Social Security:

SSI Yes No Amount: _____
SSDI Yes No Amount: _____
Survivors Yes No Amount: _____
Retirement Yes No Amount: _____
Disabled Child Yes No Amount: _____

Public Assistance/DSS Benefits

Yes No DSS Caseworker: _____
Phone: _____

V.A. Pension

Yes No Amount: _____

Payee Status

Self Rep Payee
Name: _____
Address: _____
Phone: _____

Are you employed

Yes No Where: _____

Checking Account: _____

Savings Account: _____

Property: _____

Other: _____

Statement of Need:

Please stated the reason(s) the referred individual needs this level of housing:

Please have person who is applying for services sign.

I am requesting that my referral packet be submitted to Transitional Living Services of Northern New York and its Admission Committee to determine eligibility for their programs. I understand this committee will be made up of individuals from within the agency and may include representatives from the adult programs, the Director of Adult Services, Director of Quality Assurance and Corporate Compliance and the Intake Coordinator. I give my permission for this committee to give and receive information regarding myself.

I am applying for admission to _____ program/residence.

Applicant's Signature: _____

Date: _____