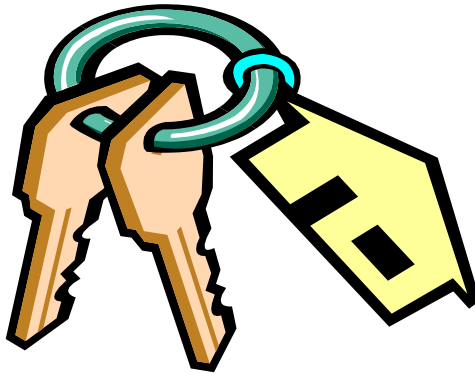


**SOUTHWEST REGION CONTINUUM OF CARE**  
**(BRIDGEPORT/NORWALK/STAMFORD)**

**SCREENING AND REFERRAL FORM**

**FOR**

**PERMANENT SUPPORTIVE HOUSING PROGRAMS**



**DATE OF REFERRAL:** \_\_\_\_\_

**TIME OF REFERRAL:** \_\_\_\_\_

**APPLICANT NAME** \_\_\_\_\_

**REFERRED BY** \_\_\_\_\_

*(Agency Name or Self)*

**CASE MANAGER** \_\_\_\_\_

**PHONE:** \_\_\_\_\_

1. Applicant Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_
2. Address: \_\_\_\_\_
3. City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
4. Zip Code of Last Permanent Address: \_\_\_\_\_
5. Phone where applicant can be reached with area code: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
6. Social Security Number: \_\_\_\_\_ 7. Date of Birth: \_\_\_\_\_ and Age \_\_\_\_\_
8. Gender: \_\_\_ M \_\_\_ F \_\_\_ Other (transgender) 8a. Primary Language: \_\_\_\_\_
9. Race:
- \_\_\_ a. American Indian/Alaskan Native \_\_\_ b. Asian \_\_\_ c. Black/African American
- \_\_\_ d. Native Hawaiian/Other Pacific Island \_\_\_ e. White \_\_\_ f. American Indian/Alaskan Native & White
- \_\_\_ j. Other multi-Racial \_\_\_ g. Asian & White \_\_\_ h. Black/African American & White
- \_\_\_ i. American Indian/Alaskan Native & Black African American
10. Ethnicity: \_\_\_ a. Hispanic or Latino \_\_\_ b. Non Hispanic or Non-Latino
11. Marital Status:
- \_\_\_ a. Single \_\_\_ c. Separated \_\_\_ e. Widowed/Widower
- \_\_\_ b. Married/cohabiting \_\_\_ d. Divorced
12. Veteran Status. A veteran is anyone who has been on active military duty. Is Applicant a Veteran: \_\_\_ Y \_\_\_ N

**FAMILY MEMBERS:** Enter family members that may live with the client

Name (Not Applicant)	Relationship to Client	Social Security Number	Gender	Date of Birth

**17. Chronically homeless person. Definition:** An unaccompanied homeless individual with a disabling condition who has either been continuously homeless for one (1) year or more **OR** has had at least four (4) episodes of homelessness in the past three (3) years. To be considered chronically homeless a person must have been on the streets or in an emergency shelter, (not in transitional housing) during these episodes of homelessness.

- a. Is this individual/family chronically homeless? \_\_\_\_\_ Y \_\_\_\_\_ N
- b. Number of episodes of homelessness in the past three years \_\_\_\_\_

**IF Number 17 is YES:** What was the last date the client lived in the community? \_\_\_\_\_

**18. Homeless Definition:** Person living in an emergency shelter or a place not meant for human habitation i.e. street, car or abandoned building

Is this individual/family Homeless? \_\_\_\_\_ Y \_\_\_\_\_ N

**19. At Risk Of Homelessness:** Someone exiting a Treatment Program, Institution, Transitional Living Program, Half-Way House or Jail with no place to live or is in danger of losing their housing or living in an inappropriate housing situation such doubled up, overcrowded or unsafe dwelling.

Is this individual/family At Risk of Homeless? \_\_\_\_\_ Y \_\_\_\_\_ N

**20. Is Applicant Receiving Services from a DMHAS Facility?:**

Dubois, Norwalk Hospital, Optimus Healthcare, SWCMHS: \_\_\_\_\_ Y \_\_\_\_\_ N

**\*If yes please contact applicant's clinician at the above agency to determine eligibility for DMHAS housing**

**21. Estimate the total time homeless in the past three years:**

- \_\_\_\_\_ a. Not homeless
- \_\_\_\_\_ b. Less than 1 month
- \_\_\_\_\_ c. At least 1 month but less than 6 months
- \_\_\_\_\_ d. At least 6 months but less than 1 year
- \_\_\_\_\_ e. At least 1 year but less than 2 years
- \_\_\_\_\_ f. 2 years but less than three
- \_\_\_\_\_ g. 3 years or more

**22. Length of homelessness this episode: (How long has this client been homeless?)**

- \_\_\_\_\_ a. Not homeless at present
- \_\_\_\_\_ b. Less than one month
- \_\_\_\_\_ c. At least 1 month but less than 6 months
- \_\_\_\_\_ g. Three years or more.
- \_\_\_\_\_ d. At least 6 months but less than 1 year
- \_\_\_\_\_ e. At least 1 year but less than 2 years
- \_\_\_\_\_ f. Two years but less than three

**\* Did Applicant Experience any Episodes of Homelessness as a Child (17 or under):** \_\_\_\_\_ Y \_\_\_\_\_ N

**23. Current living situation (Enter the one living situation where the client has been the majority of the time)**

- \_\_\_\_\_ a. Non-housing (street, park, care, bus station, etc.)
- \_\_\_\_\_ b. Emergency Shelter
- \_\_\_\_\_ c. Transitional Housing for homeless
- \_\_\_\_\_ d. Psychiatric Facility \*
- \_\_\_\_\_ e. Substance Abuse Tx Facility \*
- \_\_\_\_\_ k. Rental Housing
- \_\_\_\_\_ f. Hospital \*
- \_\_\_\_\_ g. Jail/Prison\*
- \_\_\_\_\_ g. Domestic Violence Situation
- \_\_\_\_\_ i. Living w/Relatives, Friends
- \_\_\_\_\_ j. Other \_\_\_\_\_

\* If a participant or family head(s) of household came from one of these facilities but was there less than 30 days and was living on the street or in emergency shelter before entering the treatment facility, they should be counted in either the street or shelter category, as appropriate.

**24. How was this referral with this client initiated? (Check one)**

- \_\_\_\_\_ a. Self Referral - Client initiated contact w/program
- \_\_\_\_\_ b. Outreach by Shelter + Care Staff/Hot Team Staff
- \_\_\_\_\_ c. Shelter staff or staff working in a homeless program
- \_\_\_\_\_ d. Inpatient or outpatient health/mental health program
- \_\_\_\_\_ e. Other hospital/medical staff
- \_\_\_\_\_ f. Alcohol, drug program
- \_\_\_\_\_ g. Other social service staff
- \_\_\_\_\_ h. Police
- \_\_\_\_\_ i. PHA waiting list
- \_\_\_\_\_ j. Church Staff
- \_\_\_\_\_ k. Other
- \_\_\_\_\_ l. Unknown

**25. Where did the first contact with this client take place? (Check one)**

- \_\_\_\_\_ a. Shelter or mission for the homeless
- \_\_\_\_\_ b. Street, park, outdoors
- \_\_\_\_\_ c. Soup Kitchen
- \_\_\_\_\_ d. Drop in Center
- \_\_\_\_\_ e. Mental Health Agency
- \_\_\_\_\_ f. Health Clinic
- \_\_\_\_\_ g. Hospital
- \_\_\_\_\_ h. Other (Specify) \_\_\_\_\_

**26. What was the date of your (or your agency's) first contact with client?** \_\_\_\_\_

**27. Is Applicant currently on a waiting list for any of the following:**

- Section 8  Public Housing  Bridge Subsidy  Veterans Affairs Supportive Housing (VASH)  Shelter Plus Care

28. Identified Disability (Is this client disabled as defined by HUD and/or DMHAS?) \_\_\_\_Y \_\_\_\_ N

29. If yes, Check ALL those that apply and complete attached disability determination form

- |   |  |
|---|--|
| <input type="checkbox"/> a. Mental Illness                                | <input type="checkbox"/> f. Physical disability (Sight, Hearing, Mobility) |
| <input type="checkbox"/> b. Drug Abuse                                    | <input type="checkbox"/> g. HIV/AIDS and Related Diseases                  |
| <input type="checkbox"/> c. Alcohol Abuse                                 | <input type="checkbox"/> h. Domestic Violence Survivor                     |
| <input type="checkbox"/> d. Developmental Disability                      | <input type="checkbox"/> i. Other: _____                                   |
| <input type="checkbox"/> e. Applicant requires wheelchair accessible unit |  |

30. Alcohol Rating (Indicate your assessment)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> a. Abstinence             | <input type="checkbox"/> c. Abuse      | <input type="checkbox"/> e. Severe dependence |
| <input type="checkbox"/> b. Use without impairment | <input type="checkbox"/> d. Dependence |   |

31. Drug Rating (Read the attached clinical rating scale for drugs and indicate your assessment code)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> a. Abstinence             | <input type="checkbox"/> c. Abuse      | <input type="checkbox"/> e. Severe dependence |
| <input type="checkbox"/> b. Use without impairment | <input type="checkbox"/> d. Dependence |   |

32. Is the applicant willing to participate in the service components of these programs? \_\_\_\_Y \_\_\_\_ N  
 (Note: For DMHAS RAP Opportunities and some HUD Funded Programs accepting services is not mandatory)

Using the list of services below, indicate which services would address the applicant's current/immediate needs:  
 In **right** hand column please prioritize the **THREE** (1, 2, 3) MOST IMPORTANT Services Across all Categories

<b>HEALTH CARE RELATED NEEDS</b>	<b>YES</b>	<b>NO</b>	<b>PRIORITY #</b>
Psychiatric or Emotional Support Services			
Medical Services			
Dental Services			
Detoxification from Alcohol or Substance Abuse			
Treatment for Alcohol or Substance Abuse			
Medication Support (Visiting Nurse or Med Supervision)			

<b>PERSONAL CARE/GENERAL NEEDS</b>	<b>YES</b>	<b>NO</b>	<b>PRIORITY #</b>
Support with Personal Hygiene ( shower, haircut)			
Access to Food			
Access to Clothing			
Help with Transportation (Tokens, Logisticare)			
Support Obtaining State Identification or Driver's License			
Support Obtaining Other Legal/Official Documents			

<b>HOUSING RELATED NEEDS</b>	<b>YES</b>	<b>NO</b>	<b>PRIORITY #</b>
Immediate/Emergency Shelter			
Halfway House or Transitional Living Facility			
Long-Term, Permanent Housing			
Drop-In Center or Day Program			

FINANCIAL/EMPLOYMENT NEEDS	YES	NO	PRIORITY #
Money Management Support			
Job Training Services			
Job Search Services			
Access to Public Financial Support or Disability Benefits			

33. Does client have a source of income? (e.g. SSI, SSDI, GA etc.) \_\_\_\_ Y \_\_\_\_ N

IF #33 is YES, enter the amount of the household's monthly income BY SOURCE TYPE and indicate the person receiving the income. If the household has no income, check item n. If Other, please specify.

Income Recipient	Name if Other	Source of Income	Start Date	Amount
___ Client	___ Other _____	a. Social Security Income (SSI)	_____	\$ _____
___ Client	___ Other _____	b. Social Security Disability Income (SSDI)	_____	\$ _____
___ Client	___ Other _____	c. Social Security	_____	\$ _____
___ Client	___ Other _____	d. General Assistance	_____	\$ _____
___ Client	___ Other _____	e. Temporary Aid to Needy Families (TANF)	_____	\$ _____
___ Client	___ Other _____	f. Child Support	_____	\$ _____
___ Client	___ Other _____	g. Veteran Benefits	_____	\$ _____
___ Client	___ Other _____	h. Employment Income	_____	\$ _____
___ Client	___ Other _____	i. Unemployment	_____	\$ _____
___ Client	___ Other _____	j. Medicare	_____	\$ _____
___ Client	___ Other _____	k. Medicaid	_____	\$ _____
___ Client	___ Other _____	l. Food Stamps	_____	\$ _____
___ Client	___ Other _____	m. Other (specify) _____	_____	\$ _____
___ Client	___ Other _____	n. No financial resources	_____	\$ _____

**Are there any outstanding debts** Indicate Amount in space provided:

- UI electric \_\_\_\_\_
  Gas \_\_\_\_\_
  Oil \_\_\_\_\_
  Cable \_\_\_\_\_
  Phone \_\_\_\_\_  
 Credit Card \_\_\_\_\_
  Bank \_\_\_\_\_
  Medical \_\_\_\_\_
  Other \_\_\_\_\_

**Education and Employment History:**

Highest Grade Achieved: \_\_\_\_\_ History of Special Education \_\_\_\_ (y/n)

**State the title of last 3 jobs held and the date of employment:**

- 1). Title of Job Held: \_\_\_\_\_ Date of Employment \_\_\_\_\_  
 2). Title of Job Held: \_\_\_\_\_ Date of Employment \_\_\_\_\_  
 3). Title of Job Held: \_\_\_\_\_ Date of Employment \_\_\_\_\_

**Current/Past Criminal History:**

- Criminal charges pending
  Probation (if checked provide name and # below)  
 History of assault/criminal behavior
  History of fire-setting

Probation Officer Name: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

**Contact Information:**

Community Case Manager: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_  
Psychiatrist: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_  
Therapist: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_  
Medical Physician: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

**Conservator or Payee:** \_\_\_\_\_ Financial Conservator \_\_\_\_\_ Conservator of Person \_\_\_\_\_ Payee

**Conservator Name:** \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

**Payee Name:** \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:** List person (family member, friend, sponsor, etc.) who should be contacted in case of an emergency

Emergency Contact: \_\_\_\_\_ Telephone # \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Can the staff leave a message with this person if s/he is trying to reach applicant/tenant? \_\_\_\_\_ Y \_\_\_\_\_ N

**REQUIRED FORMS FOR APPLICATION SUBMISSION:**

- APPLICATION FORM: Be sure you answered all questions, and include your telephone number.**
- FEDERAL PRIVACY ACT NOTICE**
- CONSENT FOR RELEASE OF INFORMATION ...(FORM ATTACHED)**
- INCOME VERIFICATION .....(COPY OF CHECK OR LETTER)**
- DOCUMENTED PROOF OF HOMELESSNESS ...(FORM ATTACHED)**
- DOCUMENTED PROOF OF DISABILITY .....(FORM ATTACHED)**
- SERVICE PLAN**
- MEDICATIONS LIST**

**Please submit completed applications directly to the housing program(s): See listing on next page**

**I hereby certify that the above information is true and correct to the best of my knowledge.**

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

Referring Source Name & Agency \_\_\_\_\_ Date \_\_\_\_\_

Referring Source Signature \_\_\_\_\_ Telephone: \_\_\_\_\_

**RELEASE OF INFORMATION:**

I agree for the information contained in this Referral Form to be released to any of the following agencies that have been checked off to help facilitate a referral on my behalf for housing and/or other services. I understand that the information provided in this application may be entered into the Homeless Management Information System database and may be used in preparing records pertaining to services provided by any of the following agencies who are licensed HMIS users.

**\*\* Please have the applicant initial in the box next to the agency or agencies where the applicant wishes to submit this form \*\***

Programs for Single Individuals			Initial				Initial
ABRI	Bridgeport	(203)338-0669		FCA	Norwalk	(203)604-1230 x335	
RNP	Bridgeport	(203)610-8296		Keystone	Norwalk	(203)831-6208	
CASA	Bridgeport	(203)339-4112		Norwalk Shelter	Norwalk	(203)866-1057	
Bridge House	Bridgeport	(203)335-5339		Shelter for the Homeless	Stamford	(203)348-2792	
Alpha	Bridgeport	(203)366-2809		Laurel House	Stamford	(203)324-1816	
The Connection	Bridgeport	(203)333-9078		St. Luke's	Stamford	(203)363-7982	
Hall-Brooke	Bridgeport/Norwalk	(203)362-3929		Family Centers	Stamford	(203)324-3167	
Supportive Housing Works	Bridgeport	(203)579-3180		Pathways	Greenwich	(203)622-4747	
Operation Hope	Fairfield	(203)292-5588		S + C	Regional	(203)579-7410	
Homes with Hope	Westport	(203)226-1661					

**Programs for Families**

Alpha	Bridgeport	(203)366-2809		Supportive Housing Works	Bridgeport	(203)579-3180	
The Connection	Bridgeport	(203)333-9078		Hall-Brooke	Bridgeport/Norwalk	(203)362-3929	
Catholic Charities	Bridgeport	(203)416-1317		Homes with Hope	Westport	(203)226-1661	
Operation Hope	Fairfield	(203)292-5588		CTE	Stamford	(203)352-4842	

**HIV/AIDS (HOPWA/HUD)**

St Luke's McKinney House	Stamford	(203)388-0173		MFAP	Norwalk	(203)855-9535	
Family Centers	Stamford	(203)324-3167		Catholic Charities	Bridgeport	(203)416-1317	

**Programs for Veterans**

ABRI	Bridgeport	(203)338-0669					
VASH	Regional	(203)479-8056					

**Programs for DV**

*I understand that I may withdraw this consent at any time prior to the release of the above information. This consent, if not withdrawn, will expire on \_\_\_\_\_ or twelve (12) months from the date below, if not otherwise specified. A photocopy of this application and release may be used to substitute as the original.*

\_\_\_\_\_  
Signature of Client or Person Granting Authorization

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Requestor Name

\_\_\_\_\_  
Agency

**The confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes as well as Federal Regulations 42 CFR part 2. These laws prohibit any further disclosure of the information by the recipient without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.**

**SOUTHWEST REGION CoC DISABILITY VERIFICATION FORM FOR  
PERMANENT SUPPORTIVE HOUSING PROGRAMS**

**HOMELESS OR RISK OF HOMELESSNESS VERIFICATION FORM**

Applicant Name:	
Date Form Completed:	
Referral Agency:	
Contact Name:	Contact Phone Number:

**SUPPORTIVE HOUSING PROGRAMS ELIGIBILITY**

- On the Street
- Emergency Shelter
- Transitional if they were homeless at entry
- Sub-standard housing not fit for human habitation, in car, abandoned building, building w/o utilities, housing that would not meet HUD housing quality standards, etc.
- Institution: psychiatric hospitalization, substance abuse treatment, Half-Way House or jail w/o identified housing upon discharge or resources, if they were homeless at entry
- At risk of homelessness, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Primary Reason for Homelessness:**

Mental Health Issues     Substance Abuse     Domestic Violence     Incarceration

Job Loss     Low Income     Other: \_\_\_\_\_

**VERIFICATION LETTERS**

Attached verification letter of homeless status on agency letterhead signed by agency representative.

Yes     No

Attached verification letter of eviction status signed by agency representative, landlord or family member living in dwelling.

Yes     No

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date

## HOMELESS OR AT RISK OF HOMELESSNESS VERIFICATION REQUIREMENTS

### **Living on the street; sub-standard living, not considered fit for human habitation**

- ❑ Sign and dated statements validating situation on letterhead from outreach workers and/or organizations that assisted the person in the recent past **OR**
  - ❑ Applicant should prepare a written narrative of the situation of how they came to be and are residing on the street or substandard housing **OR**
  - ❑ Written verification signed and dated on letterhead from referring social service organization or outreach worker providing information regarding where the person has been residing.
- 

### **In an emergency shelter**

- ❑ Verification signed and dated on the emergency shelter letterhead documenting where the person has been residing.
- 

### ***Persons coming from transitional housing***

- ❑ Written verification signed, dated and on letterhead from the transitional facility where the participant has been residing. Must have been homeless at entry.
- 

### ***Persons being discharged from an institution***

- ❑ Written, signed and dated verification on letterhead from the institution's staff that the participant is being discharged with no identified housing upon discharge and/or lacks the resources to obtain housing. Must have been homeless at entry.
- 

### ***Persons being evicted from a private dwelling***

- ❑ Evidence of formal eviction proceedings indicating that the participant is being evicted.
  - ❑ If there is no formal eviction and the person is forced out of the housing by circumstances beyond the applicant's control, the applicant must provide a signed and dated narrative explaining the situation.
  - ❑ Independent verification by the Property Manager or Property Staff signed and dated confirming validation of the above circumstances attesting to their validity.
-

