OFFICE ON MENTAL HEALTH/
CORE SERVICE AGENCY OF HARFORD COUNTY
STATE HOSPITAL DISCHARGE INITIATIVE
PERMANENT SUPPORTIVE HOUSING REFERRAL FORM

Applicant's Name:_____ Application Date:_____

Applicant's Phone Number: _____

Residential Rehabilitation Program (RRP) Provider: _____

Jurisdiction:_____ Address: _____

City:_____ State:_____ Zip Code:_____

Date of Birth:_____ SS#:_____ Gender:_____

Race:

American Indian/Alaskan Native	Asian
Black or African American	Native Hawaiian or Other Pacific Islander
White	Don't Know
Multiple Races	Refused

Ethnicity: Hispanic Non-Hispanic

Veteran: Yes No Veteran's Benefits: Yes No

Cash Income Received	Monthly Amount	Non-Cash Benefits	
SSI	_____	Food Stamps	_____
SSDI	_____	Medicare Number	_____
Employment	_____	Medicaid Number	_____
Other	_____	Other	_____

Legal History (Please list all charges and convictions. Please include dates, the status of charges, and describe the nature of the charges):_____

_____

_____

_____

Current Diagnosis:	ICD-10 Code:
_____	_____
_____	_____
_____	_____
_____	_____

Date of most recent hospitalization:_____

All Current Medications:	Dosage/Frequency
_____	_____
_____	_____
_____	_____
_____	_____

Current ability to take medication:

Independently With Reminders With Daily Supervision

Refuses Medication Medication Not Prescribed

Current Behavioral Health Treatment Provider(s):

Name:_____ Type of service:_____

Address:_____

Telephone Number:_____

Name:_____ Type of service:_____

Address:_____

Telephone Number:_____

Current Medical Provider(s):

Name:_____ Type of service:_____

Address:_____

Telephone Number:_____

Name:_____ Type of service:_____

Address:_____

Telephone Number:_____

Activities of Daily Living:

What type of meaningful daytime activity will the applicant be involved in while participating in the Permanent Supportive Housing Program? _____

_____

How does the applicant attend to activities of daily living?

Independent Needs moderate support Needs significant support

Preferred County/Counties of Residence:_____

Individual completing referral form:

Name:_____ Email Address:_____

Agency:_____ Type of Service:_____

Address:_____

Phone Number:_____ Fax Number:_____

PLEASE ATTACH A COPY OF THE APPLICANT'S MOST RECENT DLA-20 ASSESSMENT TO THE REFERRAL

Please try to include the following documentation with the referral:

1. A birth certificate.
2. Original SSN card
3. Photo ID
4. Award letter if receiving SSI / SSDI / Social Security, 30 days of paystubs if employed
5. Rental History (letter stating whether they are current on their rent)
6. Criminal background history

Consent Agreement for the Permanent Supportive Housing Initiative:

I, _____, agree to release information contained in this application to the Maryland Department of Health, Behavioral Health Administration, and the Office on Mental Health/Core Service Agency of Harford County, Inc. to determine eligibility for the Permanent Supportive Housing Initiative. I understand this information will not be released to any other party without my written consent.

I understand this consent is valid for 12 months from the date of my signature. I understand the Permanent Supportive Housing Initiative will require me to be involved with a Housing Coordinator. I understand I will be encouraged to participate in some type of meaningful daytime activity such as school, work, volunteering, or other vocational or skill training that I may benefit from while receiving rental assistance through the Permanent Supportive Housing Initiative.

_____ _____

Applicant's Signature Date

_____ _____

Witness Signature Date