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

Applicant's Name:_____ Application Date:_____

Preferred Pronouns: _____ Applicant's Phone Number: _____

Applicant Address: _____

City:_____ State:_____ Zip Code:_____

County of Residence: _____

Date of Birth:_____ SS#:_____

Residential Rehabilitation Program (RRP) Provider: _____

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):_____

_____

_____

Is the applicant currently on conditional release? ☐ Yes ☐ No

If yes, has the CFAP Coordinator approved a move to independent living? ☐ Yes ☐ No

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:_____

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 include the following documentation with the referral:

1. Award letter if receiving SSI / SSDI / Social Security, 30 days of paystubs if employed
2. Rental History (letter stating whether they are current on their rent)

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