

**TRANSITIONAL SERVICES, INC
PERMANENT SUPPORTIVE HOUSING PROGRAM
INITIAL SERVICES REFERRAL**

Applicant Name: _____ **Date:** _____

I. Referral Source

Self referred

Applicant Contact Phone Number _____

County / Agency referred

Agency / Hospital Name: _____

Contact person name: _____

Title / Position _____

Contact phone number: _____

II. Applicant Information

Current Address: _____
Street Address / Apt number

City, State, Zip Code

Phone number: _____

Social Security Number: _____ - _____ - _____ Date of Birth: ____ - ____ - ____

Service Coordination Unit (SCU) Number _____ - _____ - _____

Are you currently on the Section 8 waiting list? Yes ____ No ____

Current source of income: DPA SSI SSD Wages Other

Amount per month \$ _____

No income currently, applying for: _____

If currently not residing in Allegheny County, please answer next two questions:

Have you ever lived in Allegheny County? When? For how long? _____

What family members or other supports do you have in Allegheny County?

III. Current living arrangements:

- State Hospital _____
Admission Date _____ (see Section IV)
- Community Hospital _____
Admission Date _____ (see Section IV)
- LTSR _____
Admission Date _____
- CRR or Group Home _____
Admission Date _____
- PCBH _____
Admission Date _____
- Lives with family / friends
- Independent in community
- Other _____

IV. Hospital Course (ask your Social Worker to complete this section if currently in-patient)

Length of Current Admission _____
Reason for Admission _____

Have there been multiple admissions to the hospital over the last year?

No Yes, How many? _____

Has there been a diversion meeting or has one been scheduled?

No Yes, Date of meeting _____

What was the outcome? _____

Is the primary reason for considering the State Hospital due to a lack of appropriate housing or support? No Yes

Current Diagnoses:

Axis I _____

Axis II _____

Axis III _____

Where did the person live prior to admission? _____

V. Services History

Have you been diagnosed with a mental illness? yes no

What is the diagnosis? _____

Are you currently receiving treatment for mental illness or using support services? yes no

If yes, who is the provider? _____

If moving back to Allegheny County, do you anticipate using mental health services in the area? yes no

If yes, with what provider? _____

VI. Send to

Fax to: Clearinghouse Manager (412) 461-0308

OR

Mail to:
Transitional Services, Inc
Attention: Clearinghouse Manager
806 West Street
Homestead, Pa 15120

(TSI office use only)

V. Services Being Requested

- Housing Support Services
- Bridge Subsidy
- Project Based Leasing
- Contingency Fund

Clearinghouse Manager: _____

Date received: _____

Date entered into Precision Care: _____