Office-Use ONLY: Intentional Communities

 Housing Innovations

Referral for Community Housing Services

|  |  |
| --- | --- |
| Date of Referral: |  |
| Name (preferred/chosen) of person to receive services: |  |
| Legal name: |  |
| Pronouns: |  |
| Gender Identity: |  |
| Legal Gender Marker: |  |
| Date of Birth: |  |
| Race/s: |  |
| Hispanic descent (Y/N): |  |
| Veteran Status (Y/N): |  |
| Address: |  |
| Phone: |  |
| Email: |  |
| Communication Preferences (x): | Phone call Text Email Video call Other: |
| Religious Preference: |  |
| Language Preference/s: |  |
| Do you need or want an interpreter? |  |
| Social Security Number: |  |
| MA Number: (Required) |  |
| Do you have Medicare? |  |
| Source/s of income: |  |
| Which county administers your benefits? |  |
| Mental health diagnoses: |  |

Housing Information:

|  |  |
| --- | --- |
| Are you currently experiencing  homelessness? | x: YES NO  If yes, how long have you been experiencing homelessness? |
| Do you need help finding  housing? | x: YES NO |
| Do you have a housing subsidy? | x: YES NO  If yes, what subsidy is it? |
| Current living environment (x): | Hospital  Shelter  Own apartment/home  Homeless/unsheltered/no place to stay  Board and Lodge, IRTS, or Residential Facility  Nursing Home/Facility  Other (explain): |
| Are you currently at risk of losing housing? | x: YES NO  If yes, please explain: |
| Do you have any felony charges as barriers to  finding housing? | X: YES NO  If yes, please explain: |
| Do you have any evictions that might be barriers to  finding housing? | X: YES NO  If yes, please explain: |

Is there anything that you would like to share that would be helpful for us to know when starting our work together?

Emergency Contact:

|  |  |
| --- | --- |
| Who would you like to have listed as your emergency contact? | |
| Name: |  |
| Relationship: |  |
| Phone Number: |  |

Please note that a Release of Information (ROI) is required for anybody coordinating an intake on behalf of the person interested.

A blank ROI is included at the end of this referral document.

If you are the Waivered Case Manager, please submit a CSSP with this referral and ROI.

|  |  |
| --- | --- |
| Who is the person submitting this referral (if not a self-referral)? | |
| Name: |  |
| Agency Name & Address |  |
| Role: |  |
| Phone Number: |  |
| Email Address: |  |
| Fax Number: |  |

The following questions are helpful for us to develop appropriate service plans with you. However, they are optional to complete.

|  |
| --- |
| Recent Risk History (x any that apply over the past 12 months) |
| Self-injurious behavior Drug/alcohol abuse  Aggressive/ violent behaviors High medical needs  Medication non-compliance Other (list): |

|  |
| --- |
| Program/Support needs identified (x any that are needed): |
| 24-hour emergency phone counseling IHS (formerly ILS) services  Individual and family counseling\* Socialization  Recovery community Housing support services  (\*May not be available based on some factors) |

What are your talents, abilities, strengths, and skills?

What do you expect or hope that our services will provide?

Do you have any preferences for your worker (i.e., gender, language, competent in a certain subject, etc.)?

If looking for housing – what type of housing? What waitlists have already been pursued?

If you would like us to coordinate services with any of the people below, please complete these sections:

|  |  |
| --- | --- |
| **Case Manager** | |
| Name and Agency: |  |
| Contact Info: |  |

|  |  |
| --- | --- |
| **Therapist** | |
| Name and Agency: |  |
| Contact Info: |  |

|  |  |
| --- | --- |
| **Psychiatrist** | |
| Name and Agency: |  |
| Contact Info: |  |

|  |  |
| --- | --- |
| **Primary Care Provider** | |
| Name and Agency: |  |
| Contact Info: |  |

|  |  |
| --- | --- |
| **In-Home Nursing** | |
| Name and Agency: |  |
| Contact Info: |  |

|  |  |
| --- | --- |
| **PCA** | |
| Name and Agency: |  |
| Contact Info: |  |

|  |  |
| --- | --- |
| **Housing Staff** | |
| Name and Agency: |  |
| Contact Info: |  |

|  |  |
| --- | --- |
| **Anyone Else Who Is Important to You** | |
| Name and Agency: |  |
| Contact Info: |  |

Optional Narrative Section

# Our intake process asks some personal questions, and we understand that some of these topics can be hard to discuss in person. To accommodate this, we have provided space below for you to write about any or all of the topics that we typically cover in the intake.

None of these topics are required to be discussed during the intake process, so please note if you wish to not discuss any of these topics below.

Who are the people you are close to in your life? (any children, relationship history, marriage history, etc.)

Do you have a history of using substances? Do you currently use any substances? Have you ever been to treatment for substance use?

Have you experienced any physical or verbal abuse (current or past)?

Have you experienced any sexual abuse (current or past)?

Have you experienced any self-abuse or neglect (current or past)? Any suicidal ideation or attempts?

Do you have a history of violence or aggression towards others (current or past)?

**AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION**

Touchstone Mental Health

2312 Snelling Avenue Minneapolis, MN 55404

Phone: (612)-843-3340 | Fax: (763)-208-7885

|  |  |  |  |
| --- | --- | --- | --- |
| **Client Information** |  | | |
| Client name |  | Date of Birth |  |
| Previous name(s): |  | Address |  |
| Phone |  | E-Mail |  |

## Consent to Request and/or Release

I authorize Touchstone Mental Health to (x all that apply):

|  |  |  |  |
| --- | --- | --- | --- |
|  | Request and Use the following Protected Health Information from the provider(s) below |  | Release the following information to the provider(s) below |
|  |  |

## My consent above allows Touchstone to Use and/or Request the following types of information:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | Economic benefits & financial information |  |  | Court and correctional records |
|  |  |
|  |  | Treatment plan or ISP |  |  | Vocational; job status, vocational plan, reports |
|  |  |
|  |  | Chemical health history, assessment & treatment |  |  | Housing status & information |
|  |  |
|  |  | Academic status & transcripts |  |  | Progress reports |
|  |  |
|  |  | Medical history, assessment & treatment |  |  | Medication records |
|  |  |
|  |  | Lab reports |  |  | Mental Health history, assessment & treatment |
|  |  |

|  |  |
| --- | --- |
| Specific dates/years of treatment (optional) |  |
| Other Special Instructions/Limitations |  |

**Special Consent**

The following information requires special consent by law. Even if you indicate all health information above, you must specifically authorize the following information in order for it to be requested or released:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Chemical dependency program (see definition in instructions)** |  |  | **Psychotherapy notes (this consent cannot be combined with any other; see instructions)** |
|  |  |

**My consent above applies to the following individuals/provider(s):**

|  |  |
| --- | --- |
| Individual/Provider Name |  |
| Primary Contact |  |
| Address |  |
| Phone Number |  |
| Fax Number |  |

**Contact Information for person completing form**

|  |  |
| --- | --- |
| Name |  |
| Daytime Phone |  |
| Touchstone Program | Housing Innovations/Intentional Communities |
| E-Mail Address |  |

**Reason(s) for Request or Release**

By authorizing the release or request of records, you are giving permission for written information to be released and used by Touchstone Mental Health and its staff to talk to a person or provider specified above about your health information.

Reason(s) for releasing/requesting information:

|  |  |
| --- | --- |
|  | Coordination of Care |
|  | Payment |
|  | Emergency Only |
|  | Other (please explain) |

I understand that by signing this form, I am requesting that the health information specified above will be either sent or received.

I may stop this consent at any time by writing to the organization(s), facility and/or professional(s) named above. Any request to revoke release is applicable from that date forward.

I understand that when the health information specified above is sent to the third party, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.

I understand that if the organization named above is a health care provider, they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

**This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:**

|  |  |
| --- | --- |
| Release Expiration Date |  |
| Specific Event |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of client or personal representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of person obtaining authorization Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name of client or personal representative Description of personal representative’s authority