

Referral Form

Applicant Name (First, Middle, Last): _____

Date: _____

Date of Birth: _____

Completed by: _____

Referrer Email/Phone Number: _____

Relationship to applicant: _____

Applicant Phone number (if available): _____

Applicant Email (if available): _____

Eligibility/Prioritization:

- PSH provides both rental subsidy and support services to its participants. PSH staff work with participants to seek out and secure permanent housing. PSH is NOT ABLE TO PROVIDE emergency shelter, motel/hotel stays, or any type of immediate placement.
- This referral will only be valid for 90 days. If the individual is eligible for the program, and is still in need of PSH services after 90 days, please submit a new referral with updated information, as this may elevate their prioritization. PSH staff will send email reminders to referrers who have expired referrals to update them.
- All clients must be diagnosed with serious mental illness and meet the Housing and Urban Development (HUD) definition of homeless or be admitted to a state psychiatric facility to be considered. Refer to the SMI Verification and Homelessness Verification for the definitions of SMI and literally/chronically homeless.
- Priority is given in the following order: state psychiatric hospital discharges, chronically homeless, literally homeless, and unstably housed/frequent systems users.

1. Is this a referral renewal? Yes No
2. Are they diagnosed with a serious mental illness? Yes No
 - a) Conditions that qualify as a serious mental illness are: (check which apply)
 - Schizophrenia Major Affective Disorder Paranoid Disorder Organic Disorder
 - Other Psychotic Disorder Personality Disorder other mental health disorders that may lead to chronic disability.
 - b) If yes, complete SMI Verification.
 - c) If no, this individual is not eligible for PSH.
3. Are they currently homeless (living in a place not meant for human habitation, or in an emergency shelter)? If yes, complete General Homelessness Verification. Yes No
4. Are they currently residing in a state psychiatric facility and is interested in the PSH program. Yes No What facility: _____
5. Has been homeless and living or residing in a place not meant for human habitation or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last 3 years where those occasions cumulatively total at least 12 months. If yes, complete the Chronic Homelessness section of the Homelessness Verification as well as the General Homelessness Verification. Yes No
6. Are they unstably housed and a frequent systems user? Yes No
 - a) If yes, where are they currently staying?
 - Living with someone else due to economic hardship, but not on the lease.
 - Rapid Rehousing program
 - Different accommodation every few days/weeks (couch surfing)
 - Has a current lease, but facing the loss of their housing in the next 30 days due to eviction or foreclosure

Notes/comments:

7. Current HCV status:

- No voucher/no completed application. (If so, please complete an application as soon as possible.)
- Applied—on waitlist/in process
- Has active voucher
- Not eligible for voucher

Notes/comments:

8. Have they called the Centralized Housing Intake (CHI) hotline? Yes No If no, please direct them to call CHI to initiate their housing assessment process at 540-271-1701.

-CHI can help assess the individual's appropriateness for PSH, or offer some alternatives.

9. Does the individual meet any of the following criteria? *Select all that apply.*

- Moved residence two or more times in the last 120 days.
- Used the hospital emergency department two or more times in the last 60 days.
- Had two or more inpatient psychiatric hospitalizations in the last 90 days.
- Currently on probation
- Veteran
- Pending charges stemming from their mental illness or substance use diagnosis.
- Mandatory Outpatient Order (MOT) in place
- Uses 911 or Emergency Services outside of their intended purpose

Notes/comments:

Income Verification/No Income Statement

1. Is this a referral renewal? Yes No
 - a) If no, please complete this form.
 - b) If yes, has their income increased by \$200 or more or decreased by any amount? Yes No
 - i) If yes, complete the income verification or no income statement as appropriate.
 - ii) If no, please skip this form.
2. Do they have income? Yes No
 - a) If yes, complete income verification.
 - b) If no, complete no income statement.

Income verification:

1. How much income and what type do they make a month? _____
 - a) Please attach documentation to verify their income. Acceptable forms of documentation include: social security award letters, other benefit award letters, or 2-3 paystubs (not older than 60 days).
 - b) If you do not have documentation at the time of this application, please send it to PSH staff within 10 days or this referral will be considered incomplete and will not be valid.

No income verification:

This document must be completed by applicants who are not recipients of any income, benefits, or assistance from the federal, state, or local government and/or outside agency(s) at the time of application to the HRCSB PSH program or by program participants who cease to receive income from the above listed sources while they are a part of the HRCSB PSH program.

I, _____ (Applicant/participant) verify that I am unemployed and not receiving any income, benefits, or assistance from any federal, state, or local agency and/or outside agency. I understand that false statement(s) or information are punishable under Federal and State Laws, and are grounds for denial and/or termination from HRCSB PSH. I will be responsible for immediately notifying HRCSB PSH of any income I start to receive within 10 working days. I understand that failure to report income as stated above is also grounds for denial and/or termination from the program. I agree to work with my supportive services provider to identify those income resource(s) to which I may be entitled or for which I may be eligible under any federal or local agency(s) within the Commonwealth of Virginia.

Applicant/Participant Signature

Date

Homelessness Verification

1. Is this a referral renewal? Yes No
 - a) If no, please complete this form.
 - b) If yes, please still complete this as their homeless status may have changed.
2. What is their total length of homelessness? _____
 - a) Incarceration, hospital stays, and time spent in emergency shelters do not count as a break in homelessness.
3. What is the length of their current episode of homelessness? _____

Chronic Homelessness Verification

Individual is literally homeless and has third-party, intake worker, or household documentation of the following:

- Has been homeless for at least one year continuously or on at least four separate occasions in the last three years, **where the cumulative total of the four occasions is at least one year (stays in institutions of 90 days or less will not constitute a break in homelessness, but such stays are included in the cumulative total)** in a place not meant for human habitation, safe have, or an emergency shelter

CHRONICALLY HOMELESS: Yes No

General Homelessness Verification

Please attach the appropriate documentation to this service. If you do not have documentation at the time of this application, please send it to PSH staff within 10 days or this referral will be considered incomplete and will not be valid.

Homelessness Status: please select only one

- Persons living on the street or sleeping in a place not designed for or ordinarily used as a regular sleeping accommodation.

Type of documentation attached: (only one needed)

- Signed and dated written certification by person seeking services.
- Signed and dated written certification by outreach worker.

- Persons living in a shelter designed to provide temporary living arrangements (congregate/scattered site emergency shelters, transitional housing, hotels/motels paid for by a charity or government program)

Type of documentation attached: (only one needed)

- HMIS shelter record
- Written referral from previous shelter staff
- Written referral from charitable organization or government program

- Persons exiting an institution (hospital, rehab, jail) where they resided for 90 days or less and resided in a place not meant for human habitation immediately before entering institution.

Type of documentation attached: (only one needed)

- Written referral from institution

SMI Verification

1. Is this a referral renewal? Yes No
 - a) If no, please complete this form.
 - b) If yes, did their diagnosis or disability level change since their last referral? Yes No
 - i) If yes, please complete this form again.
 - ii) If no, please skip this form.
2. What is their diagnosis? _____
 - a) Please attach a signed statement or assessment (including their license number) from a licensed mental health professional (e.g. psychiatrist, psychologist, nurse, social worker, etc.) or a M.D. that states their diagnosis to this referral.
 - b) If you do not have documentation at the time of this application, please send it to PSH (psh@hrcsb.org) staff within 10 days or this referral will be considered incomplete and will not be valid.
3. Level of disability: evidence of severe and recurrent disability resulting from mental illness, that causes functional limitations in major life activities (select all that apply): (must demonstrate at least two of these criteria on a continuing or intermittent basis to qualify)
 - Is unemployed; employed in a sheltered or supportive work situation; has limited employment skills; has a poor employment history
 - Requires public financial assistance to remain in the community and may be unable to procure such assistance without help
 - Has difficulty establishing or maintaining a personal social support system
 - Requires assistance in basic living skills such as personal hygiene, food preparation, or money management
 - Exhibits inappropriate behavior that often results in intervention by the mental health or judicial system
4. Duration of illness (select all that apply): (treatment history must meet at least one of these to qualify)
 - Is expected to require services of an extended duration
 - Has undergone psychiatric treatment more intensive than outpatient care more than once in their lifetime.

Has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted their normal living situation.