

Mailing Instructions

Applications must be mailed

We will not accept applications hand delivered to
Marin Housing Authority

Applications must be postmarked between
February 16th, 2010
and

April 30th, 2010

or they will be returned

Please mail all forms to:

**Marin Housing Authority
4020 Civic Center Drive
San Rafael, Ca. 94903
Attn: S+C Waitlist**



4020 Civic Center Drive
San Rafael, CA 94903-4173

Executive Director
Dan Nackerman

Thank you for your interest in the Shelter Plus Care (S+C) Program of the Marin Housing Authority (MHA). The S+C program is designed to provide safe, secure housing and a broad range of support services to homeless, disabled individuals and families. You must be a resident of Marin County, 18 years of age or older and meet income, homeless and mental health criteria in order to be placed on the waitlist. S+C is a program of the Marin Housing Authority in collaboration with Community Mental Health Services and other community-based organizations. **You must fit all criteria in order to be placed on the waitlist.** Qualifying for the waitlist does not guarantee that you will be accepted into the S+C Program.

I have enclosed the following form(s):

1. Shelter Plus Care Interest Form
2. Interagency Referral Form
3. Release Form

Please note the following:

- **The Shelter Plus Care Interest Form must be filled out by the applicant**
- **The Interagency Referral Form must be filled out by a professional who knows the applicant's psychiatric history and diagnosis- i.e. psychiatrist, therapist, casemanager**
- **The Release Form must be signed by the applicant**

*All forms must be returned by mail and postmarked between February 16th and April 30th, 2010 in order to be considered for the S+C waitlist. **Please mail to:***

**Marin Housing Authority
4020 Civic Center Drive
San Rafael, Ca 94903
Attn: S+C Waitlist**

Please do not drop the forms off at the office as they will not be accepted. If you have difficulty with any of these forms, please call me at (415) 491-2586.

Respectfully,

Gail Mosconi, LCSW
Shelter Plus Care Program Coordinator
491-2586

Housing Authority of
the County of Marin

415/491-2525

(FAX) 415/472-2186
(TDD) 1-800-735-2929

www.marinhousing.org

For Marin Housing use only
Date Received: _____

**SHELTER PLUS CARE PROGRAM (S+C)
INTEREST FORM**

APPLICANT INFORMATION

Your Name: _____ D.O.B. _____

SSN: _____ County of Residence: _____

Address Where We Can Contact You: _____

Phone Number Where We Can Contact You: _____

Email: _____

REFERRING ORGANIZATION (IF APPLICABLE)

Referring Organization Name: _____

Contact Person: _____ Phone: _____

Your responses to the following questions will be used to determine your initial eligibility for the Shelter Plus Care (S+C) Program. Eligible applicants must be homeless, and have a serious chronic mental health disability, and meet age, residency and income criteria.

If you meet the initial S+C eligibility criteria, you will be put on the waiting list. When your name comes up on the wait list, we will contact you at the contact address provided above and schedule a formal eligibility interview. Additional information may be required before a final eligibility determination can be made.

If your contact information changes during the period of time you are on the waiting list, please update that information on your application by calling 491-2586 and leaving a message. If we are unable to contact you your name will be dropped from the waitlist.

* * * * *

1. What is your current housing situation? **(Please check only one)**

- ___ Living on the street, camping or in a car? Explain _____
- ___ Living in an emergency shelter? Name of shelter _____
- ___ Living in a transitional housing program? Name of program _____
- ___ Living temporarily with family or friends?
- ___ In a Hospital? Name of hospital _____
- ___ In a Treatment Program? Name of program _____
- ___ Renting an apartment or other housing unit?
- ___ Other (Please explain): _____

2. Describe your housing situation over past 3 years _____

3. Please list two contacts who can verify your current housing situation: (name/phone number)
 Contact # 1 _____
 Contact # 2 _____
4. What is your gross monthly income? \$ _____
5. What is the source(s) of your income? _____
6. What is your medical insurance? _____
7. Do you have a psychiatric disability? Yes No
 If you answered yes above:
 What is your diagnosis? _____
 Who is your treating psychiatrist? _____
 Casemanager or therapist? _____
8. Please list your sources of social support (i.e., family, friends, AA/NA, other): _____

9. Please describe any medical conditions you have: _____

10. The Shelter Plus Care (S+C) Program requires that participants identify their personal goals (i.e. attending school, volunteering or paid work, etc.) What personal goals can you identify beyond securing stable housing? _____

11. Are you a veteran? yes no

Please note that submitting false or inaccurate information may cause your application to be denied. I verify that the information I provided on this form is accurate to the best of my knowledge:

 Name

 Date

**MAKE SURE TO ANSWER ALL QUESTIONS COMPLETELY
 Or your application may be returned or denied**

RETURN THIS FORM BY MAIL ONLY, by April 30th, 2010 TO:

**Marin Housing Authority
 4020 Civic Center Drive
 San Rafael, CA 94903
 ATTN: S+C Waitlist**

INTERAGENCY REFERRAL FORM

Name _____ CMHS # _____
Referral Date _____ Admit Date _____ D/C Date _____
Referring Facility _____ Referring Staff _____
Phone _____ Admission Date _____ Projected D/C Date _____

IDENTIFYING INFORMATION

SS# _____ Current Mailing Address _____
DOB _____ City, State, Zip _____
Ethnicity _____ Gender _____ Marital Status _____
Work Hx/Interests _____
Description of Client Goals/Desires _____

Legal Status Vol T.Con LPS CONREP Parole Probation Rep. Payee

	Name	Address	Phone #
Emergency Contact	_____	_____	_____
Treating Psychiatrist	_____	_____	_____
Case Manager/Coordinator	_____	_____	_____
Conservator/Rep Payee	_____	_____	_____
Probation/Parole Officer	_____	_____	_____
Medical Physician	_____	_____	_____
Family Support	_____	_____	_____
Other providers	_____	_____	_____

FINANCIAL INFORMATION

CMSP # _____ Medicare # _____
MediCal # _____ Other Insurance # _____
Financially Responsible Person _____
Income Source (IF ANY SOURCES ARE PENDING, PLEASE GIVE APPLICATION DATES)
SSI \$ _____ SDI \$ _____ SSDI \$ _____ GA \$ _____ OTHER \$ _____

PSYCHIATRIC/MEDICAL STATUS

Diagnosis:
 AXIS I _____
 AXIS I _____
 AXIS II _____
 AXIS III _____
 AXIS IV Specify _____
 AXIS V Current Highest Past Year

Current Medications (Psych & Medical) _____

Allergies/Adverse Reactions to Meds _____

Takes Meds as Prescribed Yes No Takes Meds Without Assistance Yes No

Significant Reactions or responses to medications _____

Client's satisfaction with medications _____

SIGNIFICANT DIAGNOSED OR UNDIAGNOSED HEALTH PROBLEMS:

Follow up care needed? Yes No

Who will follow up/Nature of follow-up: _____

Date of last physical exam _____ TB Test _____ Result _____

Current Psychiatric hospitalization at _____

Behaviors warranting admissions: _____

Current milieu behaviors: _____

Prior Psychiatric hospitalizations: _____

Hosp. _____ Dates _____ Behaviors _____

Hosp. _____ Dates _____ Behaviors _____

CHECK ITEMS BELOW WHICH PERTAIN:

Assaultive behavior: Dates _____ Place _____

Incident details _____

Injury/charges _____

Suicide attempts: _____

Date _____ Place _____ Method _____

Date _____ Place _____ Method _____

Current assessment of suicide risk: Severe Moderate None

If OD, drug used/amount _____

Drug/Alcohol involvement prior to attempt Yes No Substance Used _____

Drug/Alcohol Use

Substance	Date Last Used	Amount Used
_____	_____	_____
_____	_____	_____

Behavior when using Drugs/Alcohol _____

Desire for Dual Diagnosis/MICA Tx Yes No Tx Plan _____

Previous experience with Sobriety, Recovery, Drug/Alcohol TX: Yes No When/Where _____

Fire Setting

Date _____ Place _____ Method _____

Date _____ Place _____ Method _____

PSYCHOSOCIAL

Indications of increased symptomatology _____

Behaviors of concern, including criminal justice involvement _____

Where has client lived in past year _____

Challenges while there _____

Reason for homelessness _____

Long-short term housing plans _____

Plan for service/follow-up, i.e., AA/NA, Dual Diagnosis, Groups, Day Tx, Decanoate Clinic, Clozaril Club, Case Management while in program _____

Referral approved Referral denied Reason _____

Interview Outcome _____



4020 Civic Center Drive
San Rafael, CA 94903-4173

Executive Director
Dan Nackerman

I give permission for S+C staff to contact any person listed on my application forms (Shelter Plus Care Interest Form and Interagency Referral Form) in order to verify the information provided and determine eligibility for the Shelter Plus Care Waitlist.

Name (print)

Signature

Date

Housing Authority of
the County of Marin

415/491-2525

(FAX) 415/472-2186
(TDD) 1-800-735-2929

www.marinhousing.org

Criteria for Shelter Plus Care Waitlist

1. Must meet HUD homeless definition
2. Must meet mental health disability criteria
3. Age 18 or over
4. Resident of Marin County
5. Must meet income eligibility criteria