Fax, mail or email (via encryption) completed form to:
Amanda Besel, 401 Fifth Ave, Suite 400, Seattle, WA 98104
Fax: 206-205-1634 or 206-205-8262
Email: abesel@kingcounty.gov
Phone: 206.263.3585

v6

King County

HOUSING AND RECOVERY THROUGH PEER SERVICS (HARPS) SCREENING

KCBHO is unable to accept incomplete applications. We recommend that the referring agency and the individual requesting assistance complete the form together to ensure that the information provided is accurate and complete

DATE: _____ **APPLICANT'S ANTICIPATED DISCHARGE DATE: _____**

SERVICES REQUESTED: ☐ **SUBSIDY ONLY** ☐ **SERVICES ONLY – NO SUBSIDY** ☐ **SERVICES & SUBSIDY**

REFERRING PROVIDER INFORMATION			
AGENCY NAME		**AGENCY SITE/PROGRAM NAME**	
AGENCY ADDRESS			
CONTACT PERSON		**PHONE NUMBER (INCLUDING AREA CODE)**	
EMAIL ADDRESS		**FAX NUMBER**	

APPLICANT INFORMATION			
LAST NAME OF APPLICANT	**FIRST NAME**	**MIDDLE NAME**	**OTHER LAST NAME**
PHONE NUMBER (INCLUDING AREA CODE)	**DATE OF BIRTH**	**PROVIDER ONE ID (IF KNOWN)**	
EMAIL ADDRESS	**ALTERNATE CONTACT PERSON (IF ANY) WITH NUMBER OR EMAIL**		

IS APPLICANT CURRENTLY RESIDING AT THE LOCATION/FACILITY IDENTIFIED ABOVE? ☐ **YES** ☐ **NO** **IF NO, PLEASE PROVIDE ADDRESS**

NAME OF FACILITY/PROGRAM	**STREET ADDRESS**	**CITY**	**ZIP CODE**

MEDICAL BENEFIT

☐ Medicaid/Apple Health ☐ Medicare, Part(s) A ◯ B ◯ C ◯ D ◯ ☐ Private ( )

INCOME: SOURCE & AMOUNT

☐ SSI $ ☐ SSDI $ ☐ Social Security $ ☐ Other ( ) $ ☐ None $0

INVOLVED IN CRIMINAL JUSTICE OR CHILD WELFARE SYSTEM? ☐ Yes ☐ No

☐ Adult Drug Diversion Ct ☐ Regional Mental Health Ct ☐ Family Treatment Ct ☐ Probation ☐ CPS ☐ Other ( )

GENDER (AS REPORTED BY APPLICANT)

☐ Woman ☐ Trans Woman ☐ Man ☐ Trans Man ☐ Nonbinary

RACE/ETHNICITY:	**PRIMARY LANGUAGE:**	**INTERPRETER REQUIRED?** ☐ YES ☐ NO

ANY DEPENDENDENTS TO BE HOUSED WITH APPLICANT? ☐ Yes ☐ No

IF YES, PROVIDE NUMBER OF DEPENDENTS AND AGES:

DESCRIBE HOUSING SITUATION PRIOR TO INAPATIENT TREATMENT AND HOUSING NEEDS/GOALS UPON DISCHARGE

HOUSING HISTORY OF PREVIOUS FIVE YEARS
APPROXIMATE DATES ACCEPTED – USE "NOTES" SECTION OR ADDITIONAL PAPER, IF NECESSARY

Type of Housing (See Housing Appendix)	Name of Facility (if applicable)	Start Date	End Date	Reasons for Leaving

CURRENT MENTAL HEALTH AND/OR SUD DIAGNOSES

IDC-10 CODE	DIAGNOSIS(ES) NAME
ICD-10 Code:	
ICD-10 Code:	
ICD-10 Code:	

ANTICIPATED OR CURRENT OUTPATIENT BEHAVIORAL HEALTH PROVIDER

Agency Name	**Street Address**	**City**	**Zip**

Contact Name	**Phone**	**Email address**

ADDITIONAL INFORMATION

Questions are intended to guide placement decisions and are NOT grounds for program exclusion.

1. MEDICAL CONDITIONS/PHYSICAL DISABIITY

Does the individual have medical conditions or physical disability that may impact housing? ☐ Yes ☐ No

If YES, please describe in "Notes" section.

2. HISTORY OF INCARCERATIONS

Has the individual been incarcerated? ☐ Yes ☐ No

3. HISTORY OF ARSON

Does the individual have a history of arson? ☐ Yes ☐ No

If YES, please describe in "Notes" section including approximate date(s)

4. SEX OFFENSE

Is the individual a registered sex offender? ☐ Yes ☐ No

If so, what level? ☐ Level 1 ☐ Level 2 ☐ Level 3

NOTES

HOUSING APPENDIX

Permanent housing - A house, apartment, trailer, hotel, dorm, barrack, and/or Single Room Occupancy (SRO), rented or owned, with expectation of long-term residency.
Temporary housing -: Living with friends or family temporarily including "couch surfing"
Transitional housing: Housing provided as part of participation in a housing readiness program with time-limited housing and supporting services provided with the goal of permanent housing.
Residential Care or Adult Family Home: May include a Group Home, Therapeutic Group Home, Board and Care, Residential Treatment, Rehabilitation Center, or Agency-operated residential care facilities. Regular neighborhood homes licensed by the state for two to six residents where staff assumes responsibility for the safety and well-being of the adult. A room, meals, laundry, supervision and varying levels of assistance with care are provided.
Skilled Nursing/Nursing/Intermediate Care Facility
Residential Drug/Alcohol treatment
Jail/Juvenile Correctional Facility
Psychiatric Inpatient Facility: Voluntary or involuntary hospitalization. Types of facility include CLIP, Inpatient Psychiatric Hospital, Veterans Affairs Hospital, or State Hospital.
Homeless: Those persons of all ages who lack a fixed, regular, and adequate nighttime residence including persons whose primary nighttime residence is one of the following: • Emergency shelter (e.g., missions, churches) where residence is on a 'night by night basis' • Living on the streets, in a vehicle, or abandoned building • Temporary living accommodations by a voucher system (e.g., motel vouchers) • Living in a public or private place not designed for, or not ordinarily used as, a regular sleeping accommodation for human beings