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: <u>abesel@kingcounty.gov</u>

Phone: 206.263.3585

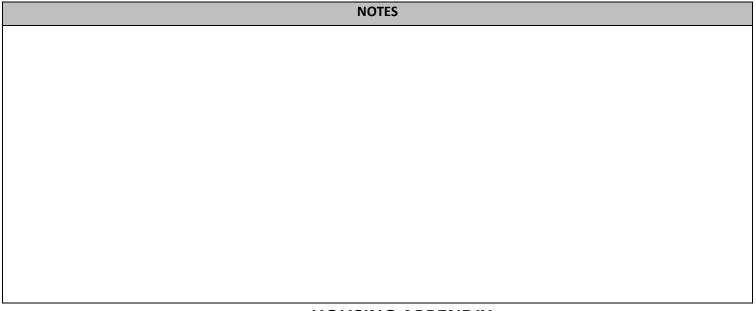


HOUSING AND RECOVERY THROUGH PEER SERVICS (HARPS) SCREENING

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 O	NLY SERVICES ONLY	- NO SUBSI	DY 🗆 SERVI	CES & SUBSIDY				
	REFERRING PROVIDER INF	ORMATION						
AGENCY NAME								
AGENCY ADDRESS				_				
CONTACT PERSON		PHONE NUMBER (INCLUDING AREA CODE)						
EMAIL ADDRESS			FAX NUMBER					
	APPLICANT INFORMA	ATION						
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 NAME OF FACILITY/PROGRAM STREET	I/FACILITY IDENTIFIED ABOVE?	CITY	NO, PLEASE PROVID	ZIP CODE				
MEDICAL BENEFIT								
☐ Medicaid/Apple Health ☐ Medicare,	Part(s) A B C D	☐ Privat	e ()				
INCOME: SOURCE & AMOUNT ☐ SSI ☐ SSDI ☐ \$ \$	☐ Social Security ☐ Other \$) □ None \$0				
INVOLVED IN CRIMINAL JUSTICE OR CHILD WELFARE S	SYSTEM?	0						
☐ Adult Drug ☐ Regional Mental ☐ Diversion Ct Health Ct	Family Treatment Ct Pro	bation \square	CPS Other	. (
GENDER (AS REPORTED BY APPLICANT)								
☐ Woman ☐ Trans Woman	☐ Man ☐ Tr	ans Man	☐ Non	oinary				
RACE/ETHNICITY: P	RIMARY LANGUAGE:		INTERPRETER REQU	UIRED? YES NO				

ANY DEPENDENDENTS TO BE HOUSED WITH APPLICANT?								
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	Type of Housing (See Housing Name of Facility (if a		Start Date	End Date	Reasons for Leaving			
Appendix)								
		CHIDDENIT NATAL	TAI HEAITH	AND/OB SU	D DIAGNOSES			
IDC-10 COD	IDC-10 CODE CURRENT MENTAL HEALTH AND/OR SUD DIAGNOSES DIAGNOSIS(ES) NAME							
ICD-10 Code:				2 10				
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 INCARCERATIO Has the individual been in		ed? □ 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 registe If so, what level? Le		fender? ☐ Yes ☐ Level 2 ☐ Lev	□ No vel 3					



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