

Fax, mail or email (via encryption) completed form to:  
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v8



King County

## HOUSING AND RECOVERY THROUGH PEER SERVICES (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? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, PLEASE PROVIDE ADDRESS			
NAME OF FACILITY/PROGRAM	STREET ADDRESS	CITY	ZIP CODE
MEDICAL BENEFIT <input type="checkbox"/> Medicaid/Apple Health <input type="checkbox"/> Medicare, Part(s) A B C D <input type="checkbox"/> Private ( )			
INCOME: SOURCE & AMOUNT <input type="checkbox"/> SSI <input type="checkbox"/> SSDI <input type="checkbox"/> Social Security <input type="checkbox"/> Other ( ) <input type="checkbox"/> None \$ \$ \$ \$ \$0			
INVOLVED IN CRIMINAL JUSTICE OR CHILD WELFARE SYSTEM? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Adult Drug <input type="checkbox"/> Regional Mental <input type="checkbox"/> Family Treatment <input type="checkbox"/> Probation <input type="checkbox"/> CPS <input type="checkbox"/> Other ( ) Diversion Ct Health Ct Ct			
GENDER (AS REPORTED BY APPLICANT)		RACE/ETHNICITY:	
PRIMARY LANGUAGE:		INTERPRETER REQUIRED? <input type="checkbox"/> YES <input type="checkbox"/> NO	

<b>ANY DEPENDENDENTS TO BE HOUSED WITH APPLICANT?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>IF YES, PROVIDE NUMBER OF DEPENDENTS AND AGES:</b>				
<b>DESCRIBE HOUSING SITUATION PRIOR TO INPATIENT TREATMENT AND HOUSING NEEDS/GOALS UPON DISCHARGE</b>				
<b>HOUSING HISTORY OF PREVIOUS <span style="color: red;">FIVE YEARS</span></b> <b>APPROXIMATE DATES ACCEPTED – USE “NOTES” SECTION OR ADDITIONAL PAPER, IF NECESSARY</b>				
Type of Housing (See Housing Appendix)	Name of Facility (if applicable)	Start Date	End Date	Reasons for Leaving
<b>CURRENT MENTAL HEALTH AND/OR SUD DIAGNOSES</b>				
IDC-10 CODE	DIAGNOSIS(ES) NAME			
ICD-10 Code:				
ICD-10 Code:				
ICD-10 Code:				
<b>ANTICIPATED OR CURRENT OUTPATIENT BEHAVIORAL HEALTH PROVIDER</b>				
Agency Name	Street Address	City	Zip	
Contact Name	Phone	Email address		
<b>ADDITIONAL INFORMATION</b> <b>Questions are intended to guide placement decisions and are NOT grounds for program exclusion.</b>				
<b>1. MEDICAL CONDITIONS/PHYSICAL DISABILITY</b> Does the individual have medical conditions or physical disability that may impact housing? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please describe in “Notes” section.				
<b>2. HISTORY OF INCARCERATIONS</b> Has the individual been incarcerated? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>3. HISTORY OF ARSON</b> Does the individual have a history of arson? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please describe in “Notes” section including approximate date(s)				
<b>4. SEX OFFENSE</b> Is the individual a registered sex offender? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what level? <input type="checkbox"/> Level 1 <input type="checkbox"/> Level 2 <input type="checkbox"/> Level 3				

## NOTES

## HOUSING APPENDIX

<b>Permanent housing</b> - A house, apartment, trailer, hotel, dorm, barrack, and/or Single Room Occupancy (SRO), rented or owned, with expectation of long-term residency.
<b>Temporary housing</b> -: Living with friends or family temporarily including “couch surfing”
<b>Transitional housing</b> : 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.
<b>Residential Care or Adult Family Home</b> : 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.
<b>Skilled Nursing/Nursing/Intermediate Care Facility</b>
<b>Residential Drug/Alcohol treatment</b> :
<b>Jail/Juvenile Correctional Facility</b>
<b>Psychiatric Inpatient Facility</b> : Voluntary or involuntary hospitalization. Types of facility include CLIP, Inpatient Psychiatric Hospital, Veterans Affairs Hospital, or State Hospital.
<b>Homeless</b> : 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: <ul style="list-style-type: none"> <li>• Emergency shelter (e.g., missions, churches) where residence is on a ‘night by night basis’</li> <li>• Living on the streets, in a vehicle, or abandoned building</li> <li>• Temporary living accommodations by a voucher system (e.g., motel vouchers)</li> <li>• Living in a public or private place not designed for, or not ordinarily used as, a regular sleeping accommodation for human beings</li> </ul>