SOJOURNER HOUSE

5460 Penn Avenue · Pittsburgh, PA 15206 · (412) 441-7783 (phone) · (412) 441-3409 (fax) · info@sojournerhousepa.org (e-mail) · www.sojournerhousepa.org

Dear Referral Agency:

Thank you for your interest in our supportive housing program, Sojourner House MOMS. Enclosed, you will find a complete packet for you and your participant to fill out.

All applicants must meet the following criteria:

- Must be homeless
- Must be in recovery from addiction (at least 90 days of documented treatment history)
- All units are 3 bedrooms; therefore the client must have a minimum of 2 children
- The head of household may be male or female with custody of at least one child and/or be pregnant
- May have co-occurring disorder (substance abuse and/or mental health)

In order for the referral packet to be considered, the packet must be completed. Below, are instructions for completing the packet and a check list of the required documents that are needed for the packet to be considered completed.

1. Applicant Self Statement
   a. To be completed by applicant
2. Referral Form (5 pages)
   a. To be completed by the therapist/counselor/social worker of the referring agency
3. Consent for the Release of Confidential Information
   a. Person making the referral, please sign as the witness
   b. Please have applicant *initial* "accept or reject" (not a check mark)
4. Letter verifying homelessness
   a. To be completed by the referral agency
5. Letter verifying 90 days treatment attendance
   a. To be completed by the treatment provider

To expedite the application process, please include (if available):

- ☐ 1. State/government photo ID of applicant
- ☐ 2. Copies of birth certificates of all members that will be living in the household
- ☐ 3. Copies of social security cards of all members that will be living in the household
- ☐ 4. Copies of insurance cards of all members that will be living in the household
- ☐ 5. The most recent DPW printout (30 days current)

Individuals who inquire on their own behalf will have materials sent to them, but packet completion rests on the provider. All applications will include an Applicant Self Statement, Referral Form (5 pages), and a Consent for the Release of Confidential Information. Completed applications can be faxed to: (484) 635-1975, or emailed to: kupsher@sjhpa.org. Questions should be directed to Karen Upsher, Family Housing Manager, at: (412) 361-1213 ext. 202.

Sincerely,

Karen Upsher
Family Housing Manager

SOJOURNER HOUSE MOMS
SUPPORTIVE HOUSING PROGRAM

REFERRAL FORM

5524 Hays Street
Pittsburgh, PA 15206

Phone: 412-361-1213
Fax: 484-635-1975

Sojourner House MOMS is a nondenominational, faith-based, transitional supported housing program that targets homeless individuals affected by co-occurring disability (mental illness and substance abuse). Minimal eligibility also requires evidence of custody of child/children. Please complete *all* items. If an item does not apply, list N/A. This *Referral Form* must be completed and signed by the referring agency. The *Applicant Self Statement* and all required documentation must be included. Incomplete referral packets will not be considered.

DEMOGRAPHIC/INFORMATION

Applicant's Last Name: _____ Maiden Name (if different):_____

First Name:_____ Middle Initial: _____

DOB: _____Age: _____Sex: _____Social Security #:_____

U.S. Citizen? : Yes ☐ No ☐ Veteran? : Yes ☐ No ☐

Race: African American ☐ Asian/PI ☐ Caucasian ☐ Hispanic ☐ Native American ☐
Other ☐

Current address/place mail and checks are received:

_____

_____

Current Phone Number: _____ Alternate Phone Number: _____

Prior Address: _____City:_____ State: _____ Zip: _____

Emergency Contact Person: _____Phone: _____

Other agencies currently involved with applicant:

_____

_____

_____

_____

Gross Monthly Household Income: _____ SS: _____ SSI: _____ DPW: _____

Food Stamps: _____ Wage/Pension: _____ VA: _____ Unemployment: _____

Other: _____

If employed, name and address of employer and length of employment:

_____

_____

SOJOURNER HOUSE MOMS
SUPPORTIVE HOUSING PROGRAM

FAMILY

Marital Status: Married ☐ Divorced ☐ Single ☐ Widow ☐

➔ If married, does individual still maintain a relationship with spouse? Yes ☐ No ☐

Does individual have a history of domestic violence? (If yes, please describe):

_____

_____

_____

_____

Number of children that will be living with the head of household while in program: _____

Please complete for the child(ren) that will live with the head of household:

Name	Age	Gender	Relationship	Will this child be living in the household full-time?		Does the head of household have legal custody?	
		M F		Yes	No	Yes	No
		M F		Yes	No	Yes	No
		M F		Yes	No	Yes	No
		M F		Yes	No	Yes	No
		M F		Yes	No	Yes	No
		M F		Yes	No	Yes	No

Does the individual have long and short-term goals for self and family? No ☐ Yes ☐ (If yes, give brief description):

_____

_____

_____

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SUPPORTIVE HOUSING PROGRAM

CLINICAL INFORMATION

Please verify diagnoses by one of the following methods: psychiatric evaluation form, clinical notes, outreach assessment form, or any documentation signed by an MD including this referral form.

Diagnosis

Axis I:_____

Axis II: _____

Axis III: _____

Axis V (GAF): _____

Current mental health treatment (includes satisfaction and compliance with treatment):

_____

_____

_____

Current MH Provider: _____ Phone: _____Last Date Seen: _____

Current Medical Issues:

_____

_____

_____

Current Medical Provider: _____Phone: _____Last Date Seen: _____

Current list of medications and who prescribed (include dosage and times):

_____

_____

_____

Drug and alcohol use/history (include drug of choice and date of last use):

_____

_____

Current D&A Provider: _____Phone: _____Last Date Seen: _____

Forensic issues:

_____

_____

_____

Current clinical status (include symptoms):

_____

_____

_____

Signs and symptoms of decompensation (include history of violence, suicidal or homicidal ideation):

_____

_____

What interventions generally work when this occurs?

Does the individual and/or a family member have other special needs that we should be aware of?

Does the individual and/or family member who would be living with applicant have a history of violence towards staff? Yes ☐ No ☐ (If yes, please describe):

Does the individual need assistance with medication management? Yes ☐ No ☐

With staying in treatment? Yes ☐ No ☐

Additional comments:

SOJOURNER HOUSE MOMS
SUPPORTIVE HOUSING PROGRAM

HOMELESS INFORMATION

How long has applicant been homeless? _____

Living situation for past 3 months (include current living situation): _____

How long can applicant remain at current residence? Why?

Ideal living situation:

Please list the applicant's current strengths, supports, resources, and accomplishments:

Please describe the skills, resources and assistance the applicant needs (financial, budgeting, education, housing, employment, health, mental health, recovery, parenting, social support, leisure, household management, etc.):

Additional comments (please include any housing options that have been explored):

Date of referral: _____ Agency: _____

Contact person: _____ Phone: _____

Please check what additional information is included with this referral form:

- ☐ Psychiatric evaluation form, clinical notes, and/or outreach assessment form
- ☐ Signed and dated statement from staff of transitional housing which describes applicant's homeless status prior to living in transitional setting
- ☐ Copy of eviction notice or written statement from evictor
- ☐ Documented attempts to identify other housing resources (if coming from institution)
- ☐ Verification of financial status
- ☐ Other
- ☐ Applicant self statement