

**York County Shelter Plus Care Program**

**York/Adams HealthChoices Management Unit**

In collaboration with the  
**Housing Authority of the City of York**

The York County Shelter Plus Care Program is available to homeless individuals who are diagnosed with a serious and persistent mental illness and are in need of assistance in securing permanent supportive housing. Each Participant entering the program must meet one of the HUD accepted definitions of homelessness, and provide documentation based on which homeless criterion is met.

Please review the following to be sure that the applicant meets one of the definitions of homelessness.

Check off the definition that applies to applicant's eligibility for the Shelter Plus Care Program and submit the required documentation:

**Applicant's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Person coming from an emergency shelter:** Dates of stay: from \_\_\_\_\_ to: \_\_\_\_\_

Shelter Name & Address: \_\_\_\_\_

Shelter Staff Name & Contact Phone: \_\_\_\_\_

Shelter Staff or Case Management Signature: \_\_\_\_\_

**Person living on the street or places not meant for human habitation**

Provide a brief description of where the person is living & for how long: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Name of Case Worker &/or Agency verifying homelessness \_\_\_\_\_

Signature of Worker \_\_\_\_\_ Date \_\_\_\_\_

**Person coming from transitional housing, but having been homeless prior to entering the facility**

Dates of Stay: from \_\_\_\_\_ to \_\_\_\_\_

Name & Address of Transitional Housing Facility \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please provide verification of individual's homeless status prior to entering the transitional living program:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Transitional Housing Staff Name \_\_\_\_\_ Signature \_\_\_\_\_

Date: \_\_\_\_\_

**Person is coming from a short stay (up to 30-consecutive days) at an institution, but was previously staying on the streets or at an emergency shelter**      Dates of Stay: from \_\_\_\_\_ to \_\_\_\_\_

Institution Name & Address \_\_\_\_\_

Verification that the applicant has been residing at institution for less than 31 days and information on previous homeless status prior to entering institution: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Institution Staff Name & Signature \_\_\_\_\_

Date \_\_\_\_\_

**Person being discharged from a longer stay at an institution**

Institution Name & Address \_\_\_\_\_

Applicant's Dates of Stay:      from \_\_\_\_\_      discharge date \_\_\_\_\_

Please explain why, without this assistance program, individual would be homeless on the street or at an emergency shelter \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Institution Staff Name & Signature \_\_\_\_\_

Date \_\_\_\_\_

**Person is being evicted within a week from a private dwelling unit, or is prohibited from staying at current residence and lacks the resources to secure other housing**

Date of eviction/termination \_\_\_\_\_

Address of current residence \_\_\_\_\_

Brief explanation of circumstances causing eviction or termination from the residence \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name & Address of person ordering eviction/termination \_\_\_\_\_

\_\_\_\_\_ Phone Number \_\_\_\_\_

Signature of person verifying termination of current residence \_\_\_\_\_

Relationship to applicant \_\_\_\_\_ Date \_\_\_\_\_



**What area do you prefer to live in? (Check all that apply)**

- |                        |                          |              |                          |
|------------------------|--------------------------|--------------|--------------------------|
| Gettysburg             | <input type="checkbox"/> | City of York | <input type="checkbox"/> |
| Dillsburg              | <input type="checkbox"/> | Windsor      | <input type="checkbox"/> |
| Dover                  | <input type="checkbox"/> | Red Lion     | <input type="checkbox"/> |
| Manchester             | <input type="checkbox"/> | Dallastown   | <input type="checkbox"/> |
| North York             | <input type="checkbox"/> | Shrewsbury   | <input type="checkbox"/> |
| East York              | <input type="checkbox"/> | Stewartstown | <input type="checkbox"/> |
| West York              | <input type="checkbox"/> | Hanover      | <input type="checkbox"/> |
| Other (Please Specify) | <input type="checkbox"/> |              |                          |
- 

**Are you looking to have anyone else living permanently in the household? \_\_\_\_\_**

- If yes, what is the relationship? \_\_\_\_\_

**Which of the following eligibility criteria is met? (Check all that apply):**

- ❖ Enrolled/Eligible for Medical Assistance \_\_\_\_\_ Medical Assistance # \_\_\_\_\_
- ❖ Mental Illness \_\_\_\_\_ Specify Diagnosis \_\_\_\_\_  
\_\_\_\_\_
- ❖ Currently Homeless? \_\_\_\_\_ Have you stayed at a Shelter? \_\_\_\_\_  
If yes, Name of Shelter and Dates of Stay \_\_\_\_\_
- ❖ Chronically Homeless \_\_\_\_\_ {HUD Def.: *An individual with a disabling condition who has been either continuously homeless for a year or more, or had at least four episodes of homelessness in the past three years.*}
  - When was most recent episode of homelessness \_\_\_\_\_
  - Main cause of homelessness \_\_\_\_\_
- ❖ Substance Use History \_\_\_\_\_ In Recovery? \_\_\_\_yes \_\_\_\_no  
Drug of Choice \_\_\_\_\_ Age at first use \_\_\_\_\_
- ❖ Transitional Age (18-29) \_\_\_\_\_
- ❖ Criminal History \_\_\_\_\_
  - What were charges and/or convictions? \_\_\_\_\_
  - Prison/Jail Time? (Specify dates of sentence): \_\_\_\_\_
  - On Probation or Parole?(Specify Dates): \_\_\_\_\_

**Do you have any medical problems/concerns?** \_\_\_\_\_ If so, please explain \_\_\_\_\_

\_\_\_\_\_

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**Are you taking any medications for the above problems?** \_\_\_\_\_ If so, please list \_\_\_\_\_

\_\_\_\_\_

**Do you have any physical handicaps that require special assistance or accommodations?** \_\_\_\_\_

If yes, please explain \_\_\_\_\_

\_\_\_\_\_

**Source of income:** \_\_\_\_\_ **Amount per month:** \_\_\_\_\_

**Which supportive services have been utilized in the past 6 months? (Check all that apply):**

- |                                    |                          |                         |                          |
|------------------------------------|--------------------------|-------------------------|--------------------------|
| ❖ Case Management                  | <input type="checkbox"/> | ❖ Social Rehab          | <input type="checkbox"/> |
| ❖ CTT/ACT                          | <input type="checkbox"/> | ❖ Crisis Intervention   | <input type="checkbox"/> |
| ❖ Substance Abuse Services         | <input type="checkbox"/> | ❖ Family                | <input type="checkbox"/> |
| ❖ Individual or Group Therapy      | <input type="checkbox"/> | ❖ Friends               | <input type="checkbox"/> |
| ❖ Medication Assistance/Management | <input type="checkbox"/> | ❖ Peer Support          | <input type="checkbox"/> |
| ❖ Mental Health Court              | <input type="checkbox"/> | ❖ Housing Assistance    | <input type="checkbox"/> |
| ❖ Compeer                          | <input type="checkbox"/> | ❖ Employment Assistance | <input type="checkbox"/> |
| ❖ Helpline                         | <input type="checkbox"/> | ❖ Education             | <input type="checkbox"/> |
| ❖ Psychiatric Rehab                | <input type="checkbox"/> | ❖ Rep Payee             | <input type="checkbox"/> |
| ❖ Drop In Center                   | <input type="checkbox"/> | ❖ Life Skills           | <input type="checkbox"/> |
| ❖ Other (Please specify)           | <input type="checkbox"/> | Probation               | <input type="checkbox"/> |

What supportive services are currently being used regularly?

Reason for Request (How will placement in this Permanent Supportive Housing Program be a benefit?)

What do you see as being the greatest challenge in transitioning to & maintaining independent living?

Please describe your strengths and support network that is in place to help you have success in the Permanent Supportive Housing Program.

**What activities would you need support/assistance doing in order to live successfully in a permanent supportive housing unit? (Check all that apply)**

- |                             |                          |                                |                          |
|-----------------------------|--------------------------|--------------------------------|--------------------------|
| Bathing/Showering           | <input type="checkbox"/> | Scheduling Needed Appointments | <input type="checkbox"/> |
| Grooming                    | <input type="checkbox"/> | Getting to Appointments        | <input type="checkbox"/> |
| Meal Preparation            | <input type="checkbox"/> | Laundry                        | <input type="checkbox"/> |
| Food Shopping/Menu Planning | <input type="checkbox"/> | Money Management/Budgeting     | <input type="checkbox"/> |
| Medication Management       | <input type="checkbox"/> | Cleaning Apartment             | <input type="checkbox"/> |
| Other (please list below)   | <input type="checkbox"/> |                                |                          |

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# YORK COUNTY HUMAN SERVICES DEPARTMENTS INFORMATION RELEASE FORM

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Area Agency on Aging | <input type="checkbox"/> Children/Youth Services  | <input type="checkbox"/> Community Service                        |
| <input type="checkbox"/> HealthChoices        | <input type="checkbox"/> Youth Development Center | <input type="checkbox"/> Human Services Department                |
| <input type="checkbox"/> Drug/Alcohol Program | <input type="checkbox"/> Veterans Affairs         | <input type="checkbox"/> Mental Health/Mental Retardation Program |

I hereby authorize (Name of Referral Source) \_\_\_\_\_ to release information to and/or receive information from **HealthChoices Management Unit** regarding the record of:

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_

The information released will be limited to the following: **The clinical and financial information needed for the purposes of making a decision on selection into a housing unit under the York/Adams County Affordable Housing Plan.**

The information will be used for the following purpose(s): **For determining Permanent Supportive Housing eligibility & ongoing assistance under the York/Adams HealthChoices County Affordable Housing Plan.**

This release is valid from (start) \_\_\_\_\_ to (end) \_\_\_\_\_ and may be revoked at any time, except to the extent that action has already been taken based on this authorization. To revoke this authorization, please notify, in writing, the York County Human Services Agency identified above. I understand that I need not consent to the release of this information. However, I choose to do so voluntarily. I understand that treatment, payment, enrollment or eligibility are *not* subject to signing this release, except as required to initiate County services. If health information is needed to initiate County services and I do not sign this release, I understand that I may not receive services. I understand that there may be a risk that the person/organization receiving my information could possibly re-disclose it without my authorization and then the confidentiality of the information might not be protected. I have read this form carefully and I understand what it means.

\_\_\_\_\_  
Signature of client/parent/guardian (Relationship) \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Staff Person \_\_\_\_\_ Date \_\_\_\_\_

### VERBAL RELEASE INFORMATION:

*This section is to be used for clients who are unable to provide a signature.*

We have witnessed that the client understands the nature of this release and has freely given his/her consent.

\_\_\_\_\_  
Witness \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Witness \_\_\_\_\_ Date \_\_\_\_\_

**Notice to the recipient of these records:** This information has been disclosed to you from records whose confidentiality is protected by State and Federal Law. Regulations limit your ability to make any further disclosure of this information without the prior written authorization of the person to whom it pertains.

**Please provide a copy of the signed release to the individual requesting the release.**



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I hereby authorize **HealthChoices Management Unit** to release information to and/or receive information from **York Housing Authority** regarding the record of:

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_

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\_\_\_\_\_  
Signature of client/parent/guardian (Relationship) \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Staff Person \_\_\_\_\_ Date \_\_\_\_\_

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Witness \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Witness \_\_\_\_\_ Date \_\_\_\_\_

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I hereby authorize **HealthChoices Management Unit** to release information to and/or receive information from

**Bell Socialization Services, Inc.** regarding the record of:

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_

The information released will be limited to the following: **The clinical and financial information needed for the purposes of making a decision on selection into a housing unit under the York/Adams County Affordable Housing Plan.**

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\_\_\_\_\_  
Signature of client/parent/guardian (Relationship)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Staff Person

\_\_\_\_\_  
Date

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\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

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I hereby authorize **HealthChoices Management Unit** to release information to and/or receive information from

**Adams-Hanover Counseling Services, Inc.** regarding the record of:

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_

The information released will be limited to the following: **The clinical and financial information needed for the purposes of making a decision on selection into a housing unit under the York/Adams County Affordable Housing Plan.**

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\_\_\_\_\_  
Signature of client/parent/guardian (Relationship)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Staff Person

\_\_\_\_\_  
Date

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\_\_\_\_\_  
Witness

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