BHSD PSH Referral Form

To be completed by approved BHSD partners:

- Approved BHSD partners will review PSH Authorization to Release & Exchange Confidential Information (ROI) with client. Client will sign the ROI.
- Approved BHSD partners will submit PSH Referral Form and signed ROI to Abode Services (pshp@abode.org) and copy BHSD point of contact (POC) or liaison:
    - CYF: **Beatriz Ballesteros-Kogan** (beatriz.ballesteros@hhs.sccgov.org)
    - AOA: **Shu-Ning Liang** (ShuNing.Liang@hhs.sccgov.org) & **Duy Le** (duy.le@hhs.sccgov.org)
    - Email Subject Line: PSHP Referral

General Information

Date Sent to Abode: _____

Agency/Provider: _____ Phone #: _____

Staff Name: _____ Email: _____

Client First Name: _____ Client Last Name: _____

Avatar/HMIS/Unique ID: _____ DOB (MM/DD/YY): _____

Current Provider: _____ Enrollment Date: _____

Care System (CSI, AOA, FDR, CYF): _____ Care Level (FSP, ACT, AOT, FACT): _____

☐ **Initial Enrollment**

ROI Attached (Y/N): _____

Gender: _____ Race/Ethnicity: _____ Veteran Status (Y/N): _____

☐ **Change Placement** (if applicable)

Old Placement End Date (if applicable): _____ Outstanding Balance: $_____

☐ **Establish Placement**

Lease Attached (Y/N): _____ **W-9 Attached** (Y/N): _____

Placement Start Date: _____ Board & Care (Y/N): _____

Placement Name: _____

Placement Address: _____

Landlord Name: _____ Phone #: _____

Landlord Address: _____ Email: _____

Contract Amount (with B&C): $_____ Move-in Rent (pro-rate 30 days): $_____

Client Portion of Rent: $_____ Security Deposit Amount: $_____

Abode Portion of Rent: $_____ Move-in Check Due Date: _____

☐ **Change Rent Amount** **Proof of Change Attached** (Y/N): _____

Old Contract Amount: $_____ New Contract Amount: $_____

Old Client Portion of Rent: $_____ New Client Portion of Rent: $_____

Old Abode Portion of Rent: $_____ New Abode Portion of Rent: $_____

New Rent Effective Date: _____

☐ **Change Provider**

Current Provider: _____ Enrollment Date: _____

Care System (CSI, AOA, FDR, CYF): _____ Care Level (FSP, ACT, AOT, FACT): _____

☐ **Live With Family** Move-in Date: _____

Family Name: _____ Relationship: _____

Family Address: _____ Phone #: _____

☐ **End Placement** (discharged MH Services)

Placement End Date: _____ Outstanding Balance: $_____

Exit Destination: _____

☐ Individual is receiving Specialty Mental Health services.

☐ BHSD Contractors adhered to all MHSA Reporting Requirements in Article 5 under California Code of Regulations, Title 9 - Rehabilitative and Developmental Services, Division 1 - Department of Mental Health Chapter 14 - Mental Health Services Act.

☐ BHSD Contractors collected all required data points in Sections #4 - #9 (Evaluation Activities, Demographic Data, Additional Data Collection Requirements, Referrals, Group Services Delivered, Detailed Outcomes) in CSS GSD Program Report and will provide to Abode Service

AUTHORIZATION TO RELEASE & EXCHANGE CONFIDENTIAL INFORMATION

I hereby authorize the organizations, agencies and/or persons listed below to release and exchange confidential information and records.

I, _____ (**Participant Name**), born on _____ (**Date of Birth**), authorize the release and exchange of confidential information between **County of Santa Clara**, **Behavioral Health Services Department** and its **approved partners**; County of Santa Clara, **Office of Supportive Housing**; and **Abode Services** on my behalf and regarding myself, my dependents, my extended family, other individuals living in my household or other persons or matters as they pertain to my housing case.

PURPOSE OF RELEASE:
Coordination of services, advocacy and case management for the specific purpose of permanent housing.

Additional individuals covered by this authorization (List names and DOB for all adults and children):

_____

_____

_____

_____

_____

I understand that this authorization is voluntary and that **I may cancel this authorization in writing at any time** by contacting a representative at either County of Santa Clara, Behavioral Health Services Department and its approved partners; County of Santa Clara, Office of Supportive Housing; and Abode Services.

I understand that if Abode Services determines that there is a conflict involving County of Santa Clara, Behavioral Health Services Department and its approved partners; County of Santa Clara, Office of Supportive Housing; and Abode Services, that Abode Services will void this release and inform me of its determination in writing.

ROI EXPIRATION DATE: _____ (if not specified, one year from the signature date)

Participant Name: _____ **Signature:** _____ **Date:** _____

If the participant is unable to sign the ROI, staff may fill the following section:

☐ **Verbal Consent** (specify reason): _____

_____

_____

Staff Name: _____ **Signature:** _____ **Date:** _____