

Pathway Homes, Inc.
10201 Fairfax Blvd. Suite 200
Fairfax, VA 22030
703-876-0390
703-876-0394 (fax)



APPLICATION FORM

Pathway's Supported Living (PSL)

Check one: _____ Fairfax
 _____ Arlington
 _____ Arlington Young Adult

PART I: TO BE COMPLETED BY REFERRING WORKER

A. Referral Information

Name: _____ Date of Referral: _____
Address: _____
Phone: _____
Primary Therapist (if different from referral source): _____

B. Client Information

Name: _____ DOB: _____ Gender: M _____ F _____
Present Address: _____ Soc. Security #: _____

Phone: _____
Insurance: Medicaid Other specify _____

Eligibility for Mental Health Support Services (must meet at least 2 of following criteria)

Check all that apply:

- _____ Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization, homelessness, or isolation from social supports.
- _____ Exhibit such inappropriate behavior that repeated interventions by mental health, social services, or judicial system are necessary.
- _____ Exhibit difficulty in cognitive ability such that they are unable to recognize danger or recognize significantly inappropriate social behavior.
- _____ Require help in basic living skill, such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health and safety is jeopardized.

Revised 9/07

D. Items to attach as part of the referral packet

1. Demographic/face Sheet
2. Mental Health Adult Assessment
3. Current Treatment Plan
4. Most recent Medication Order
5. Most recent Service Plan Review
6. Substance Abuse Assessment (*if applicable*)
7. Suicide Assessment and/or Violence Assessment (*if applicable*)
8. Provider of Choice Form
9. Any additional relevant information (i.e. discharge summaries, legal issues, and psychological testing, etc.)

E. Provider of Choice

I have reviewed with my therapist/case manager the Support Services providers available to me. My signature below indicates my selection of Pathway Homes to as my provider of choice.

Applicant Signature

Date

Referral Source Signature

Date

PART II: TO BE COMPLETED BY APPLICANT

Name: _____

Please respond to the following questions:

1. How would you like to use the services offered by Pathway Homes' Supported Living Program?

2. Please rate your skills in the following areas:

<i>SKILLS</i>	<i>N/A</i>	<i>POOR/FAIR</i>	<i>GOOD</i>	<i>EXCELLENT</i>
Personal Hygiene				
Cooking/Nutrition				
House Cleaning				
Laundry				
Grocery Shopping				
Money Management				
Public Transportation				
Medication Mgmt.				
Socialization				
Self Advocacy				

3. Describe your current or past use of alcohol and/or drugs. Please include type of substance(s) used, how much, how often and how long you used.

4. Have you ever received treatment for the abuse of alcohol or drugs? If yes, please describe.

5. What are some of your interests and talents? What do you do for fun?

6. What are your short term goals?

7. What are your long term goals?

8. Is there any other information you feel is important for us to know about you?



Authorization to Exchange Information

I hereby authorize Pathway Homes, Inc., to exchange information concerning me with the ***referral source or other providers*** listed in this application. I understand that this information will be exchanged only to assess my suitability for support services.

This authorization will automatically expire upon revocation by client.

Applicant Signature

Date

Witness Signature

Date