
James House Referral Packet

This application contains the following:

Packet Inserts

James House Application

Authorization of Release of Information

Verification of Disability

MHSRB: Plan of Care

Please include with application:

- Current Medication list
 - Most recent psychiatric evaluation
 - Diagnostic assessment
-

Date Rec'd

James House Application

Referring Agency: _____

I. APPLICANT INFORMATION

Name		Phone No.	
Address		City	State Zip
Type of housing currently living in (own apartment / temporary shelter / living with friends / etc.)		How long have you lived at this address? _____ mo. _____ yrs.	
Homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, do you have a certificate of homelessness? <input type="checkbox"/> Yes <input type="checkbox"/> No		HMIS number:
Marital Status	Education	SSN	
Race: (for statistical purposes only) <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Island		Ethnicity: (for statistical purposes only) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	

II. JAMES HOUSE ELIGIBILITY

James House is for persons who have a second disability that requires assistance in fulfilling their daily living needs and following a regimen to stabilize and maintain their health. Briefly describe the disability applicant has and why he/she needs James House.

Is this disability considered permanent? Yes No. If temporary, expected recovery period.

Do you require handicap accommodations, such as a wheelchair ramp, accessible showers, etc.? Yes No
If yes, what types of accommodations?

See attached list of documents needed to complete this application. ICAN WILL NOT REVIEW THIS APPLICATION UNTIL ALL DOCUMENTS HAVE BEEN SUBMITTED.

III. HOUSING HISTORY

Have you ever been evicted? yes no If yes, please list reason(s):

Current or most recent landlord	Why did you move from this unit?
Address or phone number of current landlord:	

IV. GENERAL INFORMATION

Do you currently engage in or do you have a history of engaging in the use of controlled substances, illegal substances or excessive alcohol use? yes no

If yes, have you completed treatment? yes no
How long have you maintained sobriety?

Are you subject to a state lifetime registration requirement for sex offenders? yes no

Have you ever been convicted of a felony? yes no

If yes, please describe the crime and year of commission.

V. FINANCIAL INFORMATION

Present source of income	Monthly amount \$
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List any and all income that you expect to receive during the next year:

If you do not currently have an income, have you applied for benefits? yes no

If yes, please list the type of benefits and date applied:

Health Insurance: <input type="checkbox"/> Medicaid <input type="checkbox"/> None <input type="checkbox"/> Medicare <input type="checkbox"/> Other (specify):	Spend down? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, amount: \$	Food Stamps <input type="checkbox"/> yes <input type="checkbox"/> no If yes, amount: \$
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Do you have a payee? <input type="checkbox"/> yes <input type="checkbox"/> no	If yes, name and address:
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Do you own a working car? <input type="checkbox"/> yes <input type="checkbox"/> no	Are you a veteran? <input type="checkbox"/> yes <input type="checkbox"/> no
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VI. APPLICANT CERTIFICATION

I certify that if selected to receive assistance, the unit I occupy will be my only residence. I understand that the above information is needed to determine my eligibility. I authorize ICAN to verify all information provided on this application and to contact previous or current landlords or other sources of credit and verification information that may be released to appropriate federal, state, or local agencies. I/we certify that the statements made in this application are true and complete to the best of my knowledge and belief. I understand that false statements or information are punishable under federal, state and/or local laws. I authorize ICAN, my case manager, and James House staff to consult with each other and make necessary and reasonable interventions to preserve the safety, sanitation and permanence of my residency.

Signature of Applicant	Date
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VII. CASE MANAGER VERIFICATION

Please describe the type and frequency of support to be provided by agency/person making this referral:

Signature of Case Manager	Date
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VIII. OWNER / MANAGER REPRESENTATIVE SIGNATURE

Signature of ICAN Staff	Date
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ICAN, Inc.

1214 Market Avenue North, Canton, Ohio 44714

Phone: (330) 455-9100 Fax: (330) 455-4702

Web: www.ican-inc.org Email: ican@ican-inc.org

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____

Date of Birth _____ Social Security Number _____

hereby grant permission to authorized representatives of ICAN, Inc. to: (Initial all that apply)

_____ **Release records about me from the agencies specified below:**

Initial

_____ **Exchange information about me (VERBALLY) with the agencies specified below:**

Initial

_____ **Coleman Professional Services**
Initial 400 W Tuscarawas Street Ste 200
Canton, Ohio 44702
Phone: 330-438-2400

_____ **Community Services**
Initial 625 Cleveland Ave. NW
Canton, Ohio 44702
Phone: 330-455-0374

_____ **Crisis Intervention Center**
Initial 832 McKinley Ave. NW
Canton, Ohio 44702
Phone: 330-455-9407

_____ **ACTT**
Initial 832 McKinley Ave NW
Canton, Ohio 44702
Phone: 330-455-1556

_____ **Phoenix Rising Behavioral Healthcare**
Initial 1930 Fremont Place SW
Canton, Ohio 44706
Phone: 330-455-5950

_____ **Trillium Family Solutions**
Initial 624 Market Ave N
Canton, Ohio 44702
Phone: 330-454-7066

_____ Other: _____
Initial

The purpose of this authorization is to permit my public mental health service provider, ICAN and Basic Accommodations staff to consult with each other and make necessary and reasonable interventions to preserve the safety, sanitation and permanence of my rent subsidy and/or housing situation.

_____ I consent to the release of the above information. I am aware that this information is
Initial disclosed from records whose confidentiality is protected by federal law. Federal Regulations (42 CFR Part 2) prohibit either party from asking any further disclosures of information shared to any person/organization not specifically listed on this form without permission.

_____ I do not consent to release/receipt/exchange of any information.
Initial

Any exceptions or exclusions for information released are listed here:

AUTHORIZATION FOR RELEASE OF INFORMATION
(continued)

This authorization will remain effective for 365 days unless an earlier date or condition/event is specified

here: _____ Initials _____

1. I understand that ***I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION IN WRITING***, by sending/providing such written notification to Property Manager at ICAN, Inc 1214 Market Ave., N., Canton, Ohio 44714. I understand that a revocation is not effective to the extent that this Authorization has been relied upon for the use or disclosure of the protected health information.
2. I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. If ICAN is the recipient, ICAN will only re-disclose information as authorized or permitted by law.
3. I understand that my housing will NOT be conditioned on whether I provide authorization for the requested disclosure.
4. I understand that I have the right to refuse to sign this authorization.
5. I further understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted by law.

I hereby state that I have read, or have had read to me, and fully understand the above statements as they apply to me and do herein expressly consent to disclosure of the above stated information for the purpose or need stated. I understand and acknowledge that this Authorization extends to all or any part of the records designated above.

Signature of Individual

Date

Witness

Date

**** A copy of this signed Authorization shall have the same force and effect as the original. ****

VERIFICATION OF DISABILITY

James House

Participant Name: _____ SSN: _____

Date of Birth: _____

Agency Providing Support Services: _____

Case Manager: _____ Phone No.: _____

Case Manager Supervisor: _____ Phone No.: _____

INSTRUCTIONS TO COMPLETE FORM

The following section must be completed by the treating psychiatrist.

I have determined that this individual has a severe and persistent psychiatric illness. Yes No

I am aware the individual also has a chronic physical illness that requires a medical plan of care. The individual's psychiatric illness impairs their ability to follow their plan of care and without daily assistance could lead to further deterioration in their health. Yes No

Signature: _____

Qualifications/Title: _____ Date: _____

PARTICIPANT RELEASE

RELEASE: I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is no older than 12 months. There are circumstances, which would require the owner to verify information that is up to 5 years old, which would be authorized by me on a separate consent, attached to a copy of this consent.

Participant Signature

Date

PENALTIES FOR MISUSING THIS CONSENT:

Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government. HUD, the PHA and any owner (or any employee of HUD, the PHA or the owner may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purposes cited above. Any person who knowingly or willfully requests, obtains or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than \$5,000. Any applicant or participant affected by negligent disclosure of information may bring civil action for damages, and seek other relief, as may be appropriate, against the officer or employee of HUD, the PHA or the owner responsible for the unauthorized disclosure or improper use. Penalty provisions for misusing the social security number are contained in the Social Security Act at 42 U.S.C. 208(f)(g) and (h). Violation of these provisions are cited as violations of 42 U.S.C. 408 (f)(g) and (h).



MENTAL HEALTH PLAN OF CARE

Instructions: Case Manager to complete in collaboration with resident & Adult Care Facility (ACF) prior to admission. Provide detailed, individualized information. File original at ACF and copies with resident and agency.

1. Name _____
2. UCI/Client Number (Optional) _____
3. Date of Birth _____
4. Social Security Number _____
5. Referring Agency (Name, Address & Phone Number) _____

6. Current Case Manager (Name & Phone Number) _____

7. Previous Address of Client _____
8. Current Address of Client _____
9. ACF (Name, Address & Phone Number) _____

10. Does the person have Medical or Psychiatric Advanced Directives?
Yes _____ No _____ (If yes, please describe them, or attach a copy to this form)

11. Does the person have a guardian?
Yes _____ No _____ (If no, go to question #13)
12. Guardian (Name, Address & Phone Number) _____

13. Has the resident ever been convicted of a crime?
Yes _____ No _____ (If yes, explain. Include any interventions or facility responsibilities needed to successfully maintain resident in community setting.)

Client Name _____

Client ID _____

14. Emergency Contact Procedures

The ACF will follow these procedures:

- A) During regular business hours
 - 1) Contact Agency Case Management office
 - 2) Ask for assigned Case Manager
 - 3) If Case Manager is unavailable, ask for the Case Manager's Supervisor or the Director of Clinical Services
- B) After business hours, weekends and holidays
 - 1) Contact the Crisis Center Hotline (330) 452-6000
 - 2) Ask for the Agency's Case Manager on call
- C) Emergency medical/legal issues: Provide contacts (Name & Phone Number)
 - 1) Guardian _____
 - 2) Physician _____
 - 3) Ambulance _____
 - 4) Hospital _____
 - 5) Probation/Parole Dept. _____
 - 6) Police/Sheriff Dept. _____

15 Describe any preparation by ACF staff to provide optimal care for the resident.

16. Assistance with activities of daily living (include resident needs, issues, prompting required & responsible party). Attach additional sheets if necessary.
- Hygiene _____

 - Medication _____

 - Medical Appointment Transportation _____

 - Psychiatric Appointment Transportation _____

 - After Hours Transportation _____

 - Nutrition _____

Client Name _____

Client ID _____

- Scheduling of Appointments _____

- Budget/Finance _____

- Socialization Needs (Home/Community) _____

- Skills Training _____

- Resident's Comments _____

- Facility Operator's Comments _____

- Agency's Comments _____

17. List current medications. Document changes between plan reviews (Include date/change).

Date	Medication	Dosage/Directions	Side Effects

Use additional sheets as needed

Note: Some common side effects of medication are changes in behavior, weight gain or loss, severe skin rash, headaches lasting 2-3 days, diarrhea lasting 2-3 days. Should there be any sign of medication side effects, please notify the nurse/case manager at the appropriate agency.

Resident's Signature Date

Case Manager's Signature Date

Case Manager Supervisor's Signature Date

ACF Operator's Signature Date