PIONEER HUMAN SERVICES
A CHANCE FOR CHANGE

Housing and Recovery Through Peer Services (HARPS) Referral Form Instructions

Please read before completing the HARPS Referral Form.

Eligibility Criteria:

HARPS Priority Population Eligibility: The following is the priority population eligibility criteria for HARPS. Those meeting these criteria will receive 2 entries into the referral lottery, described below.

- An individual is 18 years of age or older; and
- Experiencing a serious mental illness (SMI), substance use disorder (SUD), or co-occurring SMI and SUD; and
- Being released from an inpatient behavioral healthcare setting or has discharged from an inpatient behavioral healthcare setting within the past 45 days; and
- Experiencing homelessness or at risk of homelessness.

HARPS General Eligibility: The following is the general eligibility criteria for HARPS. Those meeting these criteria will receive 1 entry into the referral lottery, described below.

- An individual is 18 years of age or older; and
- Experiencing a SMI, SUD, or co-occurring SMI and SUD; and
- At risk of entering an inpatient behavioral healthcare setting or has discharged from an inpatient behavioral healthcare setting more than 45 days ago; and
- Experiencing homelessness or at risk of homelessness.

Referral Process:

Please **clearly** and **legibly** fully answer each question within the HARPS Referral Form. Pioneer Human Services (PHS) is unable to accept incomplete referral forms.

Each month, HARPS Referral Forms will be accepted during 2 separate referral windows. HARPS Referral Forms can only be submitted during these referral windows.

- 1st Referral Window: 8 am on the 1st Monday of the month to 6 pm on the 2nd Monday of the month
- 2nd Referral Window: 8 am on the 3rd Monday of the month to 6 pm on the 4th Monday of the month

Please note, if a month has 5 Mondays, there is not an additional drawing.

Send completed forms to kcharpsreferrals@p-h-s.com as a PDF or Word document, one form per email, and **label the subject line of the email and attachments with applicant initials**. Please note this email address is for forms only and is not monitored for questions. Only one submission per person per referral window is necessary.

At the end of each referral window, eligible applicants will be randomly selected to enroll in HARPS. The number of enrollments awarded during each referral window will be dependent on the current HARPS program capacity.

Selected applicants will be contacted and instructions for next steps will accompany the email of acceptance. Please follow these instructions carefully.

Applicants that were not selected to enroll in HARPS will not be contacted, and all referral forms that were not selected will be deleted. Applicants that were not selected but are still eligible for HARPS are free to reapply, but they will need to re-submit the referral form during the next referral window through a new email thread.

Please note, submission of a HARPS Referral Form does not guarantee or confirm access to HARPS housing subsidy.

Questions:

For general HARPS questions, please contact Charlotte Lefler at clefler@kingcounty.gov.

For questions related to **accepted** HARPS referrals, please contact Jennifer McPherson at Jennifer.mcpherson@p-h-s.com or Dre Hoyt at dre.hoyt@p-h-s.com. The King County HARPS phone number at PHS is 206-573-1409.

Housing and Recovery Through Peer Services (HARPS) Referral Form

Please note: You must answer each item below for the referral form to be complete. Pioneer Human Services (PHS) is unable to accept incomplete referral forms.

Referral Date: ____________ **Anticipated or Actual Discharge Date:** _______________

Services Requested

☐Subsidy and subsidy coordination services only

☐Services only-no subsidy

☐Subsidy and services

Has housing already been identified?

☐No

☐Yes, please include property name, location, and contact information:______________________________________

____

Referring Provider Information	
Provider Name (if self-referral then list "self")	**Provider Site/Program Name**
Provider Address	
Contact Person	**Phone Number with Area Code**
Email Address	**Fax Number**
Additional support or care team members for individual; name, phone, email **Name:** ____________________ **Phone Number:** ____________________ **Email: Address:** ____________________	**What is the additional support/care team member's role?** **Is this person a primary contact for coordination?** ☐Yes ☐No
Additional support or care team members for individual; name, phone, email **Name:** ____________________ **Phone Number:** ____________________ **Email: Address:** ____________________	**What is the additional support/care team member's role?** **Is this person a primary contact for coordination?** ☐Yes ☐No
Additional support or care team members for individual; name, phone, email **Name:** ____________________ **Phone Number:** ____________________ **Email: Address:** ____________________	**What is the additional support/care team member's role?** **Is this person a primary contact for coordination?** ☐Yes ☐No

Referred Individual's Information			
Last Name	**First Name**	**Middle Name**	**Suffix**
Alias or AKA	**Date of Birth**	**Phone Number** ( )	**Email Address**
Gender ☐Female ☐Male ☐Transgender-Woman ☐Transgender-Man ☐Gender Non-Conforming ☐Other ☐Do not wish to report		**Race** ☐American Indian ☐Alaska Native ☐Asian ☐Black ☐Hawaiian ☐Pacific Islander ☐White ☐Other:	
Ethnicity ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Unknown/Not Reported		**Pregnancy Status** ☐Yes ☐No ☐Unknown	**ProviderOne ID**
Primary Language		**Interpreter Required or Requested** ☐Yes ☐No	

Is the referred individual currently residing at the provider site/program name noted in the section above?

☐Yes ☐No, **if no, provide address below:**

Name of Site/Program	Address	City	Zip Code

Medical Benefit

☐Medicaid/Apple Health ☐Medicare, Part(s) ☐ A ☐ B ☐ C ☐ D ☐None
☐Private: _____

Income Source and Amount

☐ABD $_____ ☐Employment $_____ ☐SSDI $_____ ☐SSI $_____

☐Other, Type: _____$_____ ☐None $0

Involved in the criminal legal or child welfare system?

☐Yes ☐No

If yes, please indicate which apply:

☐Adult Drug Diversion Court ☐Regional Mental Health Court ☐DOC ☐Probation ☐Parole ☐BOP
☐CPS ☐Family Treatment Court ☐Criminal legal system involvement within the past 3 years
☐Other:_____

Do any dependents require housing with the referred individual?

☐Yes, if yes, list the number of dependents and ages:_____
☐No

Subsidy Request
If subsidy is requested, what is the type and approximate amount of the subsidy request. ☐Rent $_____ Per Month ☐Other, Type:_____ $_____

Housing Status
Is the referred individual currently housed? Please note, if the person being referred is in an inpatient behavioral healthcare setting and was unhoused when entering this setting, the current housing status should be listed as unhoused, even if housing after discharge has been identified. ☐Yes, if yes, what date did they move into their current residence? _____ if yes, what is the zip code the current residence? _____ if yes, what is the monthly rent without a subsidy? $_____ ☐No, if no, what is the zip code of where the referred individual is staying? _____

Describe the referred individual's housing situation prior to their inpatient behavioral healthcare stay as well as housing needs upon discharge. **If you are submitting a self-referral, include dates of the inpatient behavioral healthcare stay.** **If you are already housed or in the community, include the length of time since inpatient behavioral healthcare stay, current engagement in outpatient behavioral health services, and any other current barriers.**

Current Mental Health and/or Substance Use Disorder Diagnoses (if self-referral or staff have no access to ICD-10 Code, then list diagnosis name only)	
IDC-10 Code	**Diagnosis Name**

Anticipated or Current Outpatient Behavioral Health Provider			
Provider Name	**Address**	**City**	**Zip Code**

Contact Name	**Phone Number**	**Email Address**

If self-referral, do you need help getting outpatient behavioral health services?

☐Yes ☐No

Additional Questions
Questions are intended to guide placement decisions and are NOT grounds for program exclusion.

1. **Medical Conditions/Physical Disability: Does the individual have medical conditions or a physical disability that may impact housing?**
   ☐Yes, is so, please describe in the "Notes" section below

   ☐No

2. **History of Incarceration: Has the individual been incarcerated?**
   ☐Yes, if so, please provide reasons for incarceration(s) and approximate date(s) in the "Notes" section below

   ☐No

3. **History of Arson: Does this individual have a history of arson?**
   ☐Yes, if so, please describe in the "Notes" section including approximate date(s)

   ☐No

4. **Sex Offense: Is this individual a registered sex offender?**
   ☐Yes, if so, what level? ☐Level 1 ☐Level 2 ☐Level 3

   ☐No

Notes

Please double check your referral form. The following information **must** be included. **Referral forms without complete information cannot be accepted.**

- Name

- Date of birth
- Current housing status
    - If the person being referred is in an inpatient behavioral healthcare setting and was unhoused when entering this setting, the current housing status should be listed as unhoused, even if housing after discharge has been identified.
    - If the person being referred is unhoused, be as specific as possible. For example, indicate if the person being referred is couch surfing or sleeping outside, in a vehicle, or in a shelter.
    - Include the zip code of residence or the zip code of the last episode of homelessness prior to entering an inpatient behavioral healthcare setting. This is not the zip code of the behavioral healthcare setting.
- Income, even if income is $0, this must be listed
- Source of income, for example employment, SSI/SSDI, ABD, TANF, other benefits, or other income sources
- Ethnicity
- Services requested, meaning subsidy & subsidy coordination services only, services only – no subsidy, or services & subsidy
- Contact information