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

Please read before completing the HARPS Referral Form.

Please **clearly** and **legibly** fully answer each question within the HARPS Referral Form. Pioneer Human Services (PHS) is unable to accept incomplete referral forms. It is recommended that the referring agency and the individual requesting assistance complete the form together to ensure the information provided is accurate and complete.

Submit completed referral forms via secure email to the HARPS Referral Inbox at KCHARPSreferrals@p-h-s.com. Please note, use this email address for submitting referral forms only.

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.

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

HARPS referrals are screened in the order that they are received and are accepted on a first-come-first-served basis. Accepted referrals will be responded to individually within 5 business days from the date of submission.

Unfortunately, we anticipate that the need for HARPS services and subsidy within the King County region will be greater than program capacity. The HARPS program will close to referrals once program capacity is met for the month. When this happens, any referral forms submitted to the HARPS Referral Inbox will receive an auto-reply message indicating that the HARPS program is currently closed to referrals. The auto-reply message will also include the date that the HARPS program will re-open to referrals. Individuals that still need HARPS assistance on or after the date of re-opening will need to resubmit their referral form for review at that time.

Housing and Recovery Through Peer Services (HARPS) Referral Form

DATE: _____ **INDIVIDUAL'S ANTICIPATED or ACTUAL DISCHARGE DATE:** _____

SERVICES REQUESTED:

☐ **SUBSIDY & SUBSIDY COORDINATION SERVICES ONLY**

☐ **SERVICES ONLY – NO SUBSIDY**

☐ **SERVICES & SUBSIDY**

IS HOUSING ALREADY IDENTIFIED:

☐ **NO**

☐ **YES Please include property name, location, and contact:** _____

_____

REFERRING PROVIDER INFORMATION				
AGENCY NAME (If Self-Referral write "self" and fill in contact info and other info)		**AGENCY SITE/PROGRAM NAME**		
AGENCY ADDRESS				
CONTACT PERSON		**PHONE NUMBER (INCLUDING AREA CODE)**		
EMAIL ADDRESS		**FAX NUMBER**		
Additional support or care team members for individual; name, phone, email		**Role of supporter**	**primary for coordination Y or N**	
Additional support or care team members for individual; name, phone, email		**Role of supporter**	**primary for coordination Y or N**	
Additional support or care team members for individual; name, phone, email		**Role of supporter**	**primary for coordination Y or N**	
***If referring for subsidy and subsidy coordination services only AND request is for anything other rental payment or move-in costs list request here:**				
REFERRED INDIVIDUAL INFORMATION				
LAST NAME OF REFERRED INDIVIDUAL	**FIRST NAME**	**MIDDLE NAME**	**OTHER LAST NAME**	**SUFFIX**
PHONE NUMBER (INCLUDING AREA CODE)	**DATE OF BIRTH**	**PROVIDER ONE ID (IF KNOWN)**		
IS THE REFERRED INDIVIDUAL CURRENTLY RESIDING AT THE LOCATION/FACILITY IDENTIFIED ABOVE? ☐ **YES** ☐ **NO** **IF NO, PLEASE PROVIDE ADDRESS**				
NAME OF FACILITY/PROGRAM	**STREET ADDRESS**	**CITY**	**ZIP CODE**	
MEDICAL BENEFIT ☐ Medicaid/Apple Health ☐ Medicare, Part(s) A☐ B☐ C☐ D☐ ☐ Private ( ) ☐ None				

INCOME: SOURCE & AMOUNT

☐ SSI $ ☐ SSDI $ ☐ Social Security $ ☐ Other ( ) $ ☐ None $0

INVOLVED IN CRIMINAL JUSTICE OR CHILD WELFARE SYSTEM? ☐ Yes ☐ No

☐ Adult Drug Diversion Ct ☐ Regional Mental Health Ct ☐ DOC ☐ Probation ☐ Parole ☐ BOP ☐ CPS ☐ Other ( ) ☐ Family Treatment Court ☐ justice involvement with past 3 years

GENDER (AS REPORTED BY CLIENT)

☐ Male ☐ Female ☐ Transgender* ☐ Intersex (born with characteristics of both male and female)

*If Transgender, client's gender identity: ☐ Male ☐ Female

RACE/ETHNICITY:	**SEXUAL ORIENTATION:**

PRMARY LANGUAGE:	**INTERPRETER REQUIRED?** ☐ YES ☐ NO

ANY DEPENDENDENTS REQUIRE HOUSING WITH REFERRED INDIVIDUAL? ☐ Yes ☐ No

YES, PROVIDE NUMBER OF DEPENDENTS AND AGES:

DESCRIBE HOUSING SITUATION PRIOR TO Inpatient Treatment /Residential Facility AND HOUSING NEEDS/GOALS UPON DISCHARGE: (If self-referral include dates of treatment, hospitalization, detox, stabilization) (If already housed or in community include current location, homelessness status, length of time since residential or SUD/MH residential services, current engagement in SUD/MH outpatient, and any other current barriers)

IF SUBSIDY REQUESTED, CHECK THE TYPE AND PROVIDE APPROXIMATE AMOUNT REQUESTED:

☐ **PAST ARREARS $**	☐ **RENT $ PER MONTH**	☐ **OTHER $**

CURRENT MENTAL HEALTH AND/OR SUD DIAGNOSES (If self-referral or staff have no access to ICD-10, then list Substance use disorder and Mental Health diagnosis by name only)

IDC-10 CODE	DIAGNOSIS(ES) NAME
ICD-10 Code:	
ICD-10 Code:	
ICD-10 Code:	

ANTICIPATED OR CURRENT OUTPATIENT BEHAVIORAL HEALTH PROVIDER

Agency Name	**Street Address**	**City**	**Zip**

Contact Name	Phone	Email address
If self-referral – do you need help getting outpatient behavioral health services;	**Yes**	**No**

ADDITIONAL INFORMATION

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

1. MEDICAL CONDITIONS/PHYSICAL DISABIITY

Does the individual have medical conditions or physical disability that may impact housing? ☐ Yes ☐ No

If YES, please describe in "Notes" section.

2. HISTORY OF INCARCERATIONS

Has the individual been incarcerated? ☐ Yes ☐ No

If YES, please provide reason(s) for incarceration(s) and approximate date(s)

3. HISTORY OF ARSON

Does the individual have a history of arson? ☐ Yes ☐ No

If YES, please describe in "Notes" section including approximate date(s)

4. SEX OFFENSE

Is the individual a registered sex offender? ☐ Yes ☐ No

If so, what level? ☐ Level 1 ☐ Level 2 ☐ Level 3

NOTES

HOUSING APPENDIX

Permanent housing - A house, apartment, trailer, hotel, dorm, barrack, and/or Single Room Occupancy (SRO), rented or owned, with expectation of long-term residency.
Temporary housing - : Living with friends or family temporarily
Transitional housing: Housing provided as part of participation in a housing readiness program with time-limited housing and supporting services provided with the goal of permanent housing.
Residential Care or Adult Family Home: May include a Group Home, Therapeutic Group Home, Board and Care, Residential Treatment, Rehabilitation Center, or Agency-operated residential care facilities. Regular neighborhood homes licensed by the state for two to six residents where staff assumes responsibility for the safety and well-being of the adult. A room, meals, laundry, supervision and varying levels of assistance with care are provided.
Skilled Nursing/Nursing/Intermediate Care Facility
Residential Drug/Alcohol treatment:
Jail/Juvenile Correctional Facility
Psychiatric Inpatient Facility: Voluntary or involuntary hospitalization. Types of facility include CLIP, Inpatient Psychiatric Hospital, Veterans Affairs Hospital, or State Hospital.
Homeless: Those persons of all ages who lack a fixed, regular, and adequate nighttime residence including persons whose primary nighttime residence is one of the following: • Emergency shelter (e.g., missions, churches) where residence is on a 'night by night basis' • Living on the streets, in a vehicle, or abandoned building • Temporary living accommodations by a voucher system (e.g., motel vouchers) • Living in a public or private place not designed for, or not ordinarily used as, a regular sleeping accommodation for human beings