From Homelessness to Home

A Resource Guide For Supporting People Through a Tough Transition

Temple University
Collaborative
On Community Inclusion of Individuals with Psychiatric Disabilities

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All materials in the Appendices are included with permission.

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Disclosures: Richard Baron serves as a Board member (uncompensated) of Horizon House, Inc. Mark Salzer has served as a Board member (uncompensated) of Pathways To Housing PA (PTHPA). This document includes references to some resources and trainings from these organizations.

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Introduction

Our citizens who are homeless – unhoused, living on the streets, spending their evenings in shelters, camping in the woods surrounding rural small towns, or 'living rough' in other circumstances – are a central focus of local, state, and national efforts designed to help them find and maintain some form of permanent and supportive housing.

Professionals in the front-line of these initiatives – homeless outreach, clinical staff, peer specialists, outreach workers, case managers, and others whose work involves face-to-face contact with currently homeless individuals – know that facilitating the transition from homelessness to housing is demanding work.

This document provides a brief overview of the main issues that need to be addressed when supporting people in making the sometimes tough transition from homelessness to housing, along with a variety of resources with advice on handling conversations with clients, housing assessment forms, staff training resources, online documents, YouTube training videos, and more (all drawn from existing and effective homeless service programs across the country). These are valuable resources that direct service staff can turn to for wise guidance and practical support.

These materials are organized around four major issues that confront staff facilitating the tough transition from homelessness to housing: **Engagement, Skill Development, Supportive Services, and Community Participation**.

Engagement

While many of those who are homeless are eager to transition to a permanent home and will prove themselves skilled in managing the tasks associated with independent living, others are concerned about altering the established routines of their lives and/or are unfamiliar with and wary of the practical day-to-day demands of maintaining a permanent home. The central issues of importance are:

- Engaging with each individual in a relationship built on trust and demonstrating a high regard for the rights of those who are homeless to have choices with regard to the type, location, and nature of the permanent housing being offered
- Recognizing both the attachment that many homeless individuals have to their current lifestyles and the fears they have about being able to meet even their most basic practical and clinical needs after they have moved to an unfamiliar setting.

Engagement Resources

- ✓ Making the Transition to Permanent Housing. (https://files.hudexchange.info/resources/documents/SHPTransitionPermanentHousing.pdf). This training manual from the Corporation for Supportive Housing (CSH) provides guidance on preparing staff for working with those who are homeless as they transition to permanent housing, and includes sections on the engagement process itself, assessing needs, building client ADL and social skills, and developing individual plans, along with a variety of assessment and planning forms in its lengthy Appendix.
- ✓ Recovering From Homelessness (https://pathwaystohousingpa.org/housing-first-university/HFU-resources#)

  A half-hour training video from Pathways to Housing - a Philadelphia housing first provider, this video provides experienced guidance from supervisory and peer perspectives on the importance of building relationships based on understanding and trust, and offering individuals choices in the type and location of their housing.

- ✓ Housing Support Training Series: Practicing Motivational Interviewing to Help People Attain and Remain Housed. (http://dpss.co.riverside.ca.us/files/pdf/homeless/events/motivational-interviewing-workbook-version-2.pdf). This document provides a useful description of motivational interviewing techniques in conversations with individuals who are homeless as they consider the options available to them for permanent housing.

- ✓ Ken Kraybill on Motivational Interviewing.
  (https://www.youtube.com/watch?v=wepwlY-YsXs)

  A brief interview between a formerly homeless individual and an expert on Motivational Interviewing on the advantages of the MI approach to developing a trusting and empowering relationship with those who are homeless as they consider permanent housing options.
- ✓ Move-In Keys to Success.
  (http://www.csh.org/wp-content/uploads/2012/07/Move-InKeyspdf.pdf)

  A very practical guide of important issues to review with individuals to prepare them for moving into a new home – establishing expectations and detailing each element of the move-in process.
- ✓ Acceptance and Commitment Therapy (ACT).
  (www.goodtherapy.org/learn-about-therapy/types/acceptance-commitment-therapy)

  An alternative approach to engaging with homeless individuals focusing on acceptance of some limitations on their lives while urging a commitment to changing behaviors to better reach one's personal goals.

Skill Development

Many of those making the difficult transition from homelessness to housing already possess the knowledge, skills, and attitudes that are needed to sustain independent housing, but others may desire initial or ongoing assistance with:

- Identifying each individual's strengths and needs with regard to the basic activity-of-daily-living tasks needed to sustain their own home, and providing or linking individuals to the supports that can assist them in strengthening these needed capacities
- Acknowledging the strengths and needs of each individual with regard to the social skills that will be needed to connect to and relate effectively to landlords, neighbors, and community members in their new and possibly unfamiliar housing circumstances

Skill Development Resources

- ✓ Pathways' Strengths and Needs Assessment.
  This form assists direct service personnel at Pathways to Housing PA – a leading Housing First provider - as they ask homeless individuals to assess their own strengths and needs across a range of life dimensions (e.g., housing, social skills, income, ADL capacities, self-care, legal issues, physical health, leisure pursuit, mobility, etc.). This form is driven by the client's own observations on their current status, their needs and desires, and available resources (Appendix 1).

- ✓ Pathways' Personal Goal Plan.
  A planning document that asks service recipients to identify their personal goals and for each goal to specify the actions they will take and their support team will take to reach those goals – with space for regular progress updates (Appendix 1).
- ✓ Pathways' Environmental Assessment.
  The Environmental Matrix is a scale that evaluates the functional level of participants on the six activities identified by local regulations for Targeted Case Management staff. Individuals must be assessed every three months (Appendix 1).
- ✓ Pathways' Personal Safety Plan.
  A form for clients and staff to complete together to assess and plan for the possibility of psychiatric or other crises that emerge that may threaten the individual's ability to sustain their independent living circumstances *(*Appendix 1).
- ✓ Horizon House, Inc. (HHI) Housing Assessment Form.
  A form used by staff at Philadelphia's Horizon House Inc. homeless services to help staff and clients together develop an assessment of the individual's readiness for Permanent Supportive Housing (Appendix 2).
- ✓ HHI Environmental Matrix.
  This document provides a format for staff to assess each client's capabilities with regard to sustaining themselves in independent living (Appendix 2).
- ✓ HHI History of Challenging Behaviors.
  Housing personnel utilize this format to learn more about each individual's history of challenging behaviors – particularly with regard to their psychiatric status (Appendix 2).

- ✓ Tenant Education (CSH).
  (https://www.csh.org/toolkit/supportive-housing-quality-toolkit/housing-and-property-management/leases-and tenant-rights/)
  In addition to the range of self-assessment forms available in the CSH document noted above (Making the Transition to Permanent Housing) the CSH website also contains a useful 'fact sheet' on tenant rights.

Supportive Services

Those who are homeless may (or may not) have established linkages to an array of supportive services they rely upon, such as clinical and case management supports, financial assistance, the availability of

warming centers, showers, and food programs, and much more. A change of circumstances and neighborhoods are likely to disrupt these established patterns, and individuals moving to permanent housing will often need assistance in:

- Identifying and connecting (or re-connecting) to a variety of core supports – physical healthcare providers, mental health professionals, crisis management personnel, financial support, and more – that are essential resources to help them thrive in their new housing circumstances.
- Finding and initiating contacts with social services supports as individuals – once settled into their new homes – and exploring ways to move toward new or renewed life goals, such as continuing their educations or moving toward competitive employment.

Supportive Services Resources

Many of the resources that we have identified ask the individual for their own perspective on their needs for support and/or the goals they would like to set for themselves – including notes on their physical and mental health, substance use needs, their need for financial support, activity-of-daily-living help or instruction, re-emerging goals related to their education or employment, etc. This type of self-assessment provides an opportunity for staff to explore with the individual those social service supports the client already utilizes as well as their knowledge of or need for information about additional social service supports as they move into new communities.

Because each locality has its own network of social service supports, local staff are frequently either assumed to have a strong working knowledge of available resources or can turn to case management or other coordinating bodies for a list of available resources, key contact information, and 'insider' information on how to facilitate a client's access to care. Other generic resources include:

- ✓ How to Get Help Experiencing Homelessness. (https://endhomelessness.org/how-to-get-help-experiencing-homelssness/). The National Alliance to End Homelessness has provided a broad overview to assist local providers in accessing shelter, healthcare, food services, and homeless hotline services – with special sections focused on services for veterans, those experiencing domestic violence, and youth.
- ✓ Healthcare Services for Homeless People. (www.ncbi.nim.nih.gov/books/NBK218235) This research article provides both an overview of the crisis in healthcare for those who are homeless and a guide to healthcare resources available at state and local levels.

Community Participation

Permanent housing programs often report that newly housed individuals feel a sense of loneliness and social isolation once they have left their homeless communities behind. Individuals may likely need support both in identifying those aspects of community life they would like to pursue and in overcoming their wariness about connecting to local activities and organizations. Supporters should be prepared to help individuals in:

- Focusing on those aspects of community life of interest to each individual, and helping them then connect to specific activities – religious congregations, recreational centers, arts programs, advocacy groups, etc. - that can counter the sense of isolation many feel in new communities; and
- Supporting individuals as they pursue participation in their chosen arenas – accompanying people into new settings, identifying and developing available natural supports to assist in this process, and working with local groups themselves to help develop more welcoming community environments.

Community Participation Resources

- ✓ Well Together – A Blueprint for Community Inclusion: Fundamental Concepts, Theoretical Frameworks and Evidence.
  (http://www.tucollaborative.org/wp-content/uploads/2017/05/Wellways-Well-Together.pdf)
  This document provides an overview of: a) the definitions of community inclusion and the research-based justifications for making community participation a priority service development focus; b) the theoretical justifications for promoting community inclusion for individuals with disabilities; c) eleven core principles of community inclusion policies, programs, and practices and their research origins; and d) and a multi-sided view of community inclusion from consumer and family, clinical and rehabilitation, and community perspectives.
- ✓ Jump Starting Community Inclusion: A Toolkit.
  (http://www.tucollaborative.org/wp-content/uploads/Jump-Starting-Community-Living-and-Participation.pdf)This toolkit contains sixty-six practical first steps that community providers can take to more effectively support their service recipients' participation in everyday community life. This compendium of simple strategies focuses on policy changes, programming shifts, and practice innovations that can quickly give new life to agency and practitioner operations. The Toolkit offers a set of do-able strategies, along with links to over 100 publications and products to support your work.

- ✓ *Peer Facilitated Community Inclusion Tool Kit.* (http://www.tucollaborative.org/wp-content/uploads/Peer-facilitated-community-inclusion-ACCESSIBLE.pdf) Peers can play a critically important role in supporting increased community participation among individuals with serious mental illnesses who have been homeless. This toolkit is an excellent resource to help peers (and others) explore service recipients' goals for increasing community participation, with exercises and worksheets that peers can use to help individuals reflect on desired levels of community participation and explore existing supports and resources, including Temple's Community Participation Measure, which enables service recipients to identify their priority goals for community participation.
- ✓ Managing Risk in Community Inclusion: Promoting the Dignity of Risk and Personal Choice. (http://tucollaborative.org/wp-content/uploads/2017/05/Managing-Risk-in-Community-Integration-Promoting-the-Dignity-of-Risk-and-Supporting-Personal-Choice.pdf) This 52 page document provides an introduction to the concepts of community inclusion, the types of risk – to consumers, agencies, and communities – that are of concern, and effective strategies to anticipate, minimize, and grapple with risk in ways that continue to promote personal dignity and choice – with a series of useful instruments to plan ahead.

Additional Resources

Here are some additional resources that might be useful in the following areas:

Information on Independent Supportive Housing

There are a variety of descriptions of independent supportive housing programming – a nationally recognized 'best practice' – that staff can explore to learn more about the philosophical underpinnings of this approach, the supporting research with regard to its effectiveness, and guidelines for day-to-day operations of direct service workers.

- ✓ Housing First Manual. (https://www.hazelden.org/store/item/385155 – for purchase). This manual provides a comprehensive overview of the 'housing first' model - the most widely utilized form of independent supportive housing, with information on program structure, principles and operating guidelines, supporting research, support services, and relationships with communities.

- ✓ Housing First University (https://pathwaystohousingpa.org/housing-first-university) HFU provides training, technical assistance, and consultation on the housing first model of independent supportive housing, and offers access online to half-hour training videos on such topics as 'recovering from homelessness,' developing 'harm reduction' policies and practices, and building a therapeutic alliance with service recipients.
- ✓ Supportive Housing Helps Vulnerable People to Live and Thrive in the Community (2016). (https://www.cbpp.org/research/housing/supportive-housing-helps-vulnerable-people-live-and-thrive-in-the-community). This research-based article summarizes the essential aspects of the supportive housing approach and the significant amount of research pointing to its success in helping homeless people move to and sustain independent housing.
- ✓ Permanent Supportive Housing: An Evidence Based Practices Kit. (www.pacenterforexcellence.pitt.edu/documents/SMA10-4510-us-Training) As part of a series of Evidence-Based Practices Kits, NIMH provides an overview of the permanent supportive housing model, its research base, and step-by-step instructions (with many supporting materials) for establishing permanent supportive housing programs.

National Resources

This resource guide also provides links to several resources – national advocacy groups, housing training initiatives, model programs, etc. **-** that can be of use to individual staff, program supervisors, and those with mental illnesses who are homeless themselves.

- ✓ Corporation for Supportive Housing (CSH) (https://www.csh.org/) The Corporation for Supportive Housing is one of the nation's longest providers of permanent supportive housing services, offering a wide range of training to local providers. The CSH website contains numerous practical resources.
- ✓ H.U.D. Exchange (www.hudexchange.info)The Office of Housing and Urban Development maintains the Exchange website to offer research, materials, and guidance on the delivery of permanent housing for a variety of populations.
- ✓ National Alliance to End Homelessness (www.endhomelessness.org) The National Alliance's website offers information and resources to both homeless advocates and housing first providers in its continuing effort to shape public policies in the homelessness arena.

- ✓ National Coalition for the Homeless
  (www.nationalhomeless.org) The National Coalition brings together major organizations around the country to advocate for improved resources: its website provides a wealth of information and practical advice.
- ✓ National Resource Center on Homelessness
  (www.coalitionforthehomeless) The National Resource Center gathers materials from researchers, advocates, and homeless services providers, and makes them available through its website.

- ✓ Supportive Housing Network of New York
  (www.shnny.org) SHNNY coordinates policy development, advocacy, and program and staff training to broaden the availability of supportive housing programs throughout the State of New York.

Appendix 1

Forms and Assessments Developed By:

Pathways to Housing PA

(https://pathwaystohousingpa.org/)

Housing First University

(https://pathwaystohousingpa.org/housing-first-university)

Included with Permission: Please Contact This Organization for More Information

PATHWAYS TO HOUSING – Strengths & Needs Assessment
Participant's Strengths, Needs, Interests, and Wishes
(Must be completed within 30 days of service registration.)

Participant: _____ DOB: _____ Agency: Pathways to Housing

Considerations	**Current Status** What is going on today? Where am I right now?	**Individual's Desires &Aspirations** What do I want? Where do I want to be?	**Resources: Personal or Social** What do I have available now?
	Life's Domains	**Goals**	**Resources & Strengths**
Housing/Living Situation			
● Time at current residence ● Experiences w/ roommates ● Experiences w/ family ● Highest level & time			
Social Skills			
● Family Supports ● Social & Spiritual supports ● How does consumer identify self & others? (men, women, authority)			

Income, Benefits, and Insurance			
● Money to meet needs ● Money management skills ● Insurance to meet medical needs			
Daily Living Skills			
● Bathing, hair care, dressing ● Cooking & menu planning ● Food & clothing shopping ● Laundry & cleaning			
Legal			
● Current Issues ● Probation ● Parole			
<u>Considerations</u>	**<u>Current Status</u>** What is going on today? Where am I right now?	**<u>Individual's Desires &Aspirations</u>** What do I want? Where do I want to be?	**<u>Resources: Personal or Social</u>** What do I have available now?

Health			
● Physical/Medical ● Mental/Psychiatric			

● Substance Use ● Level of interest			
Education/Vocational Training/Work			
● Current situation ● Highest level achieved ● Strengths & Interests			
Leisure Interests & Recreational Skills			
● In home interests/activities ● Out of home interests/activities ● Level of satisfaction			
Mobility			
● Use of public transportation ● Able to drive ● Arrange for transportation ● Satisfaction & Interest			

● Other Participant Interests & Skills:

_____

● People who participant feels are a support:

Name	Relationship	Day Phone #	Evening Phone #

Participant Signature:	Date:	Team Leader:	Date:
Staff Signature:	Date:	Other:	Date:

Additional information should be added to this form as discovered, by writing it in the appropriate box, with the date written & with the consumer's initials. Prioritize life safety & health goals, if indicated by serious risks to the consumer's safety or health. A new **Strengths & Needs Assessment** must be completed with consumer not more than 6 months from the date the consumer signed this form.

Personal Goal Plan

Agency: Pathways to Housing PA

My Name: _____ BSU #: _____

Address: _____ Type of Residence: _____

My Strengths for this goal: _____

RECOVERY STATUS (check one): ____ Dependent/Unaware ____ Dependent/Aware ____ Independent/Unaware ____Independent/Aware

I want to work on a goal in the following area (check only one goal for this page):

- ☐ Clinical Care
- ☐ Peer Support & Relationships
- ☐ Family Support
- ☐ Work/Activities
- ☐ Power & Control
- ☐ Stigma
- ☐ Community Involvement
- ☐ Access to Resources
- ☐ Educational
- ☐ Spirituality
- ☐ Other

Goal (What do I want or need, what do I want to improve my life?)	**My Action Steps** (Things I'm responsible for doing to reach my goal)	**My TCM Team's Action Steps** (How my TCM team will support me)	**Others' Action Steps** (How others will support me)	**Next date to review my progress**
	Start Date: _____ End Date: _____	Start Date: _____ End Date: _____	Start Date: _____ End Date: _____	
	Start Date: _____ End Date: _____	Start Date: _____ End Date: _____	Start Date: _____ End Date: _____	
	Start Date: _____ End Date: _____	Start Date: _____ End Date: _____	Start Date: _____ End Date: _____	

_____ ☐ Agree ☐ Disagree _____ ☐ Agree ☐ Disagree

My Signature Date Other Signature Title Date

_____ ☐ Agree ☐ Disagree _____ ☐ Agree ☐ Disagree

If consumer refuses to sign, explain Date Other Signature Title Date

_____ ☐ Agree ☐ Disagree _____ ☐ Agree ☐ Disagree

TCM Signature Date Other Signature Title Date

_____ ☐ Agree ☐ Disagree _____ ☐ Agree ☐ Disagree

TCM Supervisor Date Other Signature Title Date

Personal Goal Plan Updates & Encounter Form

Participant Name: _____

Pathways to Housing PA, 5201 Old York Rd., Suite 108, Philadelphia, PA 19141

DOB/SSN: _____

"I certify that I am actively involved in receiving housing and case management services. I understand that payment and satisfaction of claims will be from public funds (federal, state, and local), and that any false claims statements, or documents, or concealment of material facts may be prosecuted under applicable law."

DATE	**Update Notes** (Participant must **INITIAL** each update)	**Client Initials**

CLOSE OUT	**REASON FOR CLOSE:** **Staff Signature:** **Date:**	

PLAN

The Personal Goal Plan (Unified Service Plan) is the document used by the team to help the participant develop action steps for achieving a desired goal, help the participant establish time frames for performing those action steps, help the team determine what support is needed for the goal, who is responsible for that support, and to provide a history of activities leading up to either the achievement, postponement, or termination of the goal. Use one sheet for each goal. Agencies will be expected to submit all Personal Goal Plans kept for each participant since the last concurrent review.

Environmental Matrix Assessment

Participant name: _____ **Social Security number**: _____

The Environmental Matrix is a scale that evaluates the functional level of participants on the six activities identified by regulation as Targeted Case Management. Individuals must be assessed every 3 months.

Pathways to Housing PA provides services at the Intensive Case Management level which generally requires an Environmental Matrix Score of **3 or higher**. Team 6 participants may score **3** to maintain this level of care. If a participant scores below these levels consult with your supervisor regarding an appropriate referral.

Scores range from "0" (No assistance needed) to "5" (Needs significant assistance in this area):

1. Assessment and Service Planning _____
2. Informal Support Network Building _____
3. Use of Community Resources _____
4. Linking and Assessing Services _____
5. Monitoring of Service Delivery _____
6. Problem Resolution _____

Subtotal: _____

Environmental Matrix Score: _____

Environmental Matrix Score=Average (Subtotal divided by 6)

Recommended Level of Targeted Case Management Service: TCM

Approved Level of Targeted Case Management Service: TCM

Signature of Participant/Personal Representative: _____

Relationship to Participant (*if applicable*):_____

Signature of Witness/Staff: _____ **Date**: _____

HOUSING FIRST University

Personal Safety Plan

Participant Name: _____ Date: _____

What are the signs that I might be in a "bad" or dangerous place for myself or others?
1. 2. 3.
Things I can do myself to take my mind off my problems :
1. 2. 3.
People who can help distract me if I'm feeling unsafe:
1. Name _____ Phone # _____ 2. Name _____ Phone # _____ 3. Name _____ Phone # _____
Places I can go to take my mind off things:

1. Place _____
2. Place _____
3. Place _____

Things I can do to make the area around me safe:

1.
2.
3.

Professionals or agencies I can contact during a crisis:

<u>In an emergency, call 911</u>

1. Name _____ Phone # _____
2. Name _____ Phone # _____
3. Your Agency's On Call # 000-000-0000 Dial Extension _____ for Team/Department/etc. ___
4. Local Crisis Response Center: _____
5. Preferred Crisis Response Center: _____
6. Warmline 1-855-507-WARM (9276) Peer helpline to talk to people who can relate to you
7. Crisis Intervention Hotline 215-686-4420 (local) Anxiety, stress, or substance use crisis helpline
8. Suicide Prevention Lifeline 1-800-273-TALK (8255) If you are thinking about suicide or feel hopeless.
9. Philadelphia Domestic Violence Hotline 1-866-723-3914 Helpline if there is violence in your relationship.

Steps for what to do when feeling bad and might need support.

Order them in level of your need. It is okay to skip steps but it might be helpful to figure out what is happening with you to know when to skip forward.

Please keep this in a place where you can easily access it.

With your permission, your team may also keep a copy for reference and update.

Adapted from: Stanley, B. & Brown, G.K. (2011). Safety planning intervention: A brief intervention to mitigate suicide risk. Cognitive and Behavioral Practice. 19, 256-264

Appendix 2

Forms and Assessments Developed By:

Horizon House, Inc.

(https://www.hhinc.org/)

Included with Permission: Please Contact This Organization for More Information

HORIZON HOUSE, INC.

Participant Assessment of Residential Stability

Participant Name _____ Date _____

Case Manager/Support Staff Information (if applicable) _____

_____

_____

_____

Current Residence/Living Situation _____

_____

Prior History of Independent Living _____

_____

Mental Health Diagnosis/Treatment _____

_____

Substance Abuse History/Treatment _____

_____

Current Income (monthly) _____ Source _____

HISTORY OF HOMELESSNESS

1. Prior living situation (Emergency Shelter, Safe Haven, Substance Abuse Treatment Facility, Streets etc.)_____
2. Length of stay in prior living situation?_____
3. Approximate date homelessness started?_____
4. Number of times client has been on the street, ES, or SH in the past 3 years?_____
5. Total number of months client has been on the street, ES, or SH in the past 3 years?_____
6. If prior living situation was a substance abuse treatment facility, did you stay less than 90 days? _____

___ _____

MENTAL HEALTH MANAGEMENT

6 = Not Applicable, 5 = Very Good, 4 = Good, 3 = Adequate, 2 = Poor, 1 = Very Poor						
Understanding of Mental Illness	6	5	4	3	2	1
Compliance with Mental Health Treatment/Medications	6	5	4	3	2	1
Ability to Cope with Mental Illness	6	5	4	3	2	1
Strength of support systems with respect to Mental Health	6	5	4	3	2	1
Use of Sponsor and/or support systems	6	5	4	3	2	1
Self-Esteem	6	5	4	3	2	1
Control of anger	6	5	4	3	2	1
Is Participant currently on disability due to MH diagnosis?	Yes			No		
Does Mental Illness prevent participant from maintaining self-sustaining employment?	Yes			No		

SUBSTANCE ABUSE MANAGEMENT

6 = Not Applicable, 5 = Very Good, 4 = Good, 3 = Adequate, 2 = Poor, 1 = Very Poor						
Understanding of addiction	6	5	4	3	2	1
Understanding of need to attend D&A meetings	6	5	4	3	2	1
Attendance at D&A meetings	6	5	4	3	2	1
Strength of support systems with respect to addictions	6	5	4	3	2	1
Understanding of triggers (List here:)	6	5	4	3	2	1
Ability to avoid triggers	6	5	4	3	2	1
Ability to maintain sobriety	6	5	4	3	2	1

ACTIVITIES OF DAILY LIVING

6 = Not Applicable, 5 = Very Good, 4 = Good, 3 = Adequate, 2 = Poor, 1 = Very Poor						
Ability to maintain personal hygiene						
Body care (bathing, use of deodorant, etc.)	6	5	4	3	2	1
Hair care (shampooing, cutting, etc.)	6	5	4	3	2	1
Dental care (visiting dentist, brushing teeth, etc.)	6	5	4	3	2	1
Clothing						
Ability to wash clothing	6	5	4	3	2	1
Ability to wear appropriate clothing	6	5	4	3	2	1
Mobility						
Ability to understand and follow directions	6	5	4	3	2	1
Ability to use public transportation	6	5	4	3	2	1
Money Management						
Ability to make and follow a budget	6	5	4	3	2	1
Ability to pay rent/program fees on time	6	5	4	3	2	1
Ability to use a bank	6	5	4	3	2	1
Ability to save money	6	5	4	3	2	1
Ability to distinguish between wants and needs	6	5	4	3	2	1
Ability to do comparison shopping	6	5	4	3	2	1

ACTIVITIES OF DAILY LIVING (continued)

Nutrition						
Ability to understand basic nutrition (4 food groups, etc.)	6	5	4	3	2	1
Ability to maintain a nutritious diet with respect to health needs						
Ability to use kitchen appliances	6	5	4	3	2	1
Ability to follow recipes	6	5	4	3	2	1
Ability to shop for nutritious foods	6	5	4	3	2	1
Household Management						
Ability to keep bedroom clean	6	5	4	3	2	1
Ability to keep kitchen clean	6	5	4	3	2	1

Ability to keep bathroom clean	6	5	4	3	2	1
Interpersonal skills						
Ability to interact socially with others	6	5	4	3	2	1
Ability to work with others	6	5	4	3	2	1
Ability to live with others	6	5	4	3	2	1
Ability to appropriately stand up for self	6	5	4	3	2	1
Ability to resolve conflict	6	5	4	3	2	1
General						
Ability to make and keep own appointments	6	5	4	3	2	1
Ability to care for own possessions	6	5	4	3	2	1
Ability to go to bed and get up on time	6	5	4	3	2	1
Ability to obtain personal identification	6	5	4	3	2	1
Ability to maximize case management supports	6	5	4	3	2	1

EDUCATION

6 = Not Applicable, 5 = Very Good, 4 = Good, 3 = Adequate, 2 = Poor, 1 = Very Poor						
Is a high school graduate or has obtained GED	Yes			No		
Has completed some post-high school education list here:_____	Yes			No		
Ability to read and write at a level required to function in society. If "poor" or "very poor", list estimated reading level (grade) here:	6	5	4	3	2	1
Ability to attend GED review and/or college-level courses in pursuit of career goals.	6	5	4	3	2	1

VOCATIONAL/EMPLOYMENT

6 = Not Applicable, 5 = Very Good, 4 = Good, 3 = Adequate, 2 = Poor, 1 = Very Poor						
Ability to participate in a vocational training program	6	5	4	3	2	1
Compliance with current or past vocational training program	6	5	4	3	2	1
Ability to develop short and long-term career goals	6	5	4	3	2	1
Resume preparation and interviewing skills	6	5	4	3	2	1
Ability to obtain self-sustaining employment						
In the next 6 months	6	5	4	3	2	1
In the next 12 months	6	5	4	3	2	1
Ability to maintain self-sustaining employment	6	5	4	3	2	1

INCOME

Participant currently has a monthly income of $ _____ from:

_____ DPA

_____ TANF, timeframe (months remaining) _____

_____ SSI

_____ SSDI

_____ Employment at _____

BENEFITS

Participant receives the following benefits:

_____ Food stamps

_____ Medical Assistance (list HMO here: _____)

_____ Medicare

_____ VA benefits

_____ Other (list here:)

COMMENTS

PERSON(S) COMPLETING THIS FORM:

_____ _____

Signature Date

_____ _____

Signature Date

ENVIRONMENTAL MATRIX ADULT SCORING SHEET

PARTICIPANT'S NAME: _____

ID# (SOCIAL SECURITY/CIS/BSU): _____

SCORES:

1. Assessment and Service Planning _____
2. Informal Support Network Building _____
3. Use of Community Resources _____
4. Linking and Assessing Services _____
5. Monitoring of Service Delivery _____
6. Problem Resolution _____

SUBTOTAL: _____

ENVIRONMENTAL MATRIX SCORE: SUBTOTAL / 6 = _____

OTHER FACTORS/ISSUES AFFECTING SCORE:

_____

_____

_____

_____

_____

ENVIRONMENTAL MATRIX

Professional Judgment: opinion based on a thorough and ethical analysis of facts, data, history, and issues in accordance with one's training and experience

Recommended Level of Targeted Case Management Service: _____

Participant Signature: _____Date: _____

Person Completing the Form: _____Date: _____

Approved Level of Targeted Case Management Service: _____

Reviewer: _____Date: _____

TCM ENVIRONMENTAL MATRIX – ADULTS
INSTRUCTIONS

The Environmental Matrix – Adults is a scale that evaluates the functional level of participants on the six activities identified by regulation as Targeted Case Management activities. Cultural competency will be recognized throughout the entire evaluation process and the entire document. Individuals must be assessed in the following areas, in a face-to-face interview with the evaluator. Individuals should be reassessed as needed, but no less than every six months.

1. Assessment and Service Planning
2. Informal Support and Network Building
3. Use of Community Resources
4. Linking and Accessing Services
5. Monitoring of Service Delivery
6. Problem Resolution

This scale has a range from 0 to 5 with the following values for each activity

0	1	2	3	4	5
No assistance needed	Minimal assistance needed		Needs Moderate assistance in this area		Needs Significant assistance in this area

All six activities are ranked on the above scale. The evaluator must complete the environmental matrix in a face-to-face, strengths-based assessment interview with the participant. Evaluators should incorporate in their assessment a recognition/determination of cultural strengths (i.e. extended family, allocation of family resources, the decision-making process, values, etc.). The evaluator should consider the individual's strengths and needs in the following life domains for each assessment area in order to produce a score that reflects the full dimension of need:

- Housing/living situation
- Education/vocation
- Income/benefits/financial management
- Mental Health treatment
- Alcohol and other drug use
- Socialization/support
- Activities of daily living
- Medical treatment
- Legal situation
- Transportation issues
- Criminal justice system involvement

Each area is defined at the "1," "3," and "5" levels (See attached Environmental Matrix) and the subtotal score is divided by 6 to obtain the EM Score (when scoring the individual, refer to the Environmental Matrix – TCM Service Scoring Grid which identifies the expected frequency of TCM contact needed for the individual for that particular assessment area). Scoring levels on individual assessment areas may be gradated to the 0.5 level only; this allows for minor differentiation of participant need without compromising the integrity of the scale.

Looking at the behavior, inclusive of the lowest level of functioning of the participant during the last ninety (90) days, rate the participant's functional level in each of the six areas. Please note that the rating for each area should be made in whole numbers; in cases where there are extraordinary factors that make the assignment of whole numbers extremely difficult, if not impossible, 0.5 points may be added to or subtracted from the base scores. The sum of the six (6) scores should then be taken and divided by 6 and the resulting subtotal score should be reviewed and compared to other known factors that may affect the participant's need for service. This should be noted on the scoring sheet. If after averaging the scores, the average is lower by at least 2 points than any one value given in any one assessment area (e.g. if a person's average is 2 and he/she received a score of 4 in any one area), the evaluator must provide written justification for assignment to the level that corresponds to the average, rather than the higher value.

The Environmental Matrix score, your professional judgment, and other information (e.g. cultural factors, records of past treatment, psychiatric evaluations, psychosocial summaries) that impacts on the participant's level of need should then be considered and the Recommended Level of TCM service should be entered on the recommended level of TCM line of the Scoring Sheet. (These levels are consistent with minimum levels of contact as defined in *Chapter 5221, Intensive Case Management* regulations and Bulletin *OMH-93-09, Resource Coordination: Implementation*). If the recommended level of TCM service differs from the Environmental Matrix score, the difference must be justified with professional judgment in the "Other Factors/Issues Affecting Score" section of the scoring sheet.

Note: The level of service indicated by the assessment represents the individual's needs at the time of assessment. Service intensity could change as an individual's needs and/or desires for service change.

Please note:

Although a person may not meet the eligibility criteria and/or the Environmental Matrix formulary, inclusive of professional judgment and other information that impacts on the individual's need for the service, he/she may be authorized for Targeted Case Management Services upon the recommendation of the County Administrator and/or designee.

ASSESSMENT & SERVICE PLANNING

The participant is able to provide meaningful and accurate information regarding own mental health status and needs. The participant, with possible assistance from the targeted case manager, identifies, formulates, and expresses personal goals and objectives and can correlate these into concrete service needs and activities. The TCM should take into consideration that the behavioral health system may pose a number of barriers which serve as obstacles to service planning (i.e. language, perceived/actual institutional racism/discrimination, etc.)

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

0 = Participant does not need/or request assistance in this area

1 = Participant is able to provide meaningful/relevant/accurate information regarding own mental health status. Participant is able to identify and formulate and express personal goals and objectives with minimal assistance from others. Participant is able to translate/correlate these goals and objectives, with minimal direction, into concrete service needs and activities

3 = Participant needs and/or requests moderate assistance in identifying and conveying information regarding own mental health status/problems. Participant needs and/or requests moderate assistance from others in order to identify, formulate, and express personal goals and objectives. Participant needs and/or requests moderate assistance from others to translate/correlate needs and goals into concrete service needs and activities.

5 = Participant needs and/or requests significant assistance from others to provide any meaningful information regarding own mental health status and/or needs. Participant is unable to express neither personal goals nor objectives without assistance. Participant needs and/or requests significant assistance from others to design/formulate service plan and activities.

INFORMAL SUPPORT NETWORK BUILDING

The participant identifies, communicates, and interacts with family, friends, significant others, and community groups from whom the participant may gain informal support. The TCM should recognize that service system barriers may impede the participant from interacting with family, friends, significant others and community groups. The participant may need the assistance of the targeted case manager and/or others to identify, enhance and/or maintain existing relationships and the encouragement to develop new ones.

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

0 = Participant does not need/or request assistance in this area.

1 = Participant is able to identify and provide meaningful/accurate/relevant information about family, friends, significant others, and social/religious groups with whom participant interacts and from whom participant may gain informal support. Participant is able, with minimal assistance, to access and maintain positive relationships with these people and groups who provide personal social support and/or companionship.

3 = Participant needs and/or requests moderate assistance in identifying and communicating with family, friends, significant others, and social/religious groups from whom participant may gain informal support. Participant needs and/or requests moderate assistance from others in order to enhance and/or maintain existing relationships and to develop new ones.

5 = Participant is unable to neither identify nor interact with family, friends, significant others, and/or social/religious groups who may serve as personal supports. Participant has few, if any, personal or familial relationships and is unable/unwilling to interact positively, if at all, with these persons or groups. Participant needs and/or requests significant assistance from others to elicit information and support on his/her behalf.

USE OF COMMUNITY RESOURCES

The participant is able to identify, understand, and articulate daily living needs as well as those community/neighborhood resources that may be needed to meet these needs. The participant may need additional support from the targeted case manager in utilizing the services that may go beyond the realm of traditional mental health/substance abuse services. TCM must recognize cultural and linguistic needs as an important element in articulating daily living needs and resources. Many services may not be available in the immediate community and be less effective if located outside the community.

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

0 = Participant does not need/or request assistance in this area.

1 = Participant is able, when encouraged, to identify and articulate daily living needs. Participant is able to access, navigate, and utilize community/neighborhood resources with minimal assistance. Participant's needs may be fulfilled through the use of existing community resources such as social/religious groups, libraries, stores, directories, and public transportation and participant is able to utilize these with minimal assistance.

3 = Participant needs and/or requests moderate assistance in identifying daily living needs as well as those community resources needed to meet these needs. When directed to community resources such as social/religious groups, libraries, stores, directories, and public transportation, the participant may require and/or request moderate assistance to access and utilize these resources in order to accomplish a planned task.

5 = Participant is unable to neither identify nor understand daily living needs. Participant is not familiar with community/neighborhood resources and has had very few, if any, positive experiences while living in the community. Participant needs and/or requests significant assistance to access, navigate, or utilize existing community resources.

LINKING AND ACCESSING SERVICES

The participant is able to locate, gain access, and maintain contact and services with the service providers that have been identified as needed in the treatment or service plan. The treatment or service plan must recognize the cultural and linguistic needs of the participant. At times, the targeted case manager may be needed to provide assistance in nontraditional and/or assertive ways to successfully gain and maintain these resources.

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this		Needs significant assistance in this

0 = Participant does not need/or request assistance in this area.

1 = Participant is able, with minimal assistance from others, to locate and gain access to services identified in the treatment or service plan. Participant is able, when encouraged, to establish and maintain appointments/services with appropriate service providers with minimal assistance. Participant needs and./or requests minimal assistance by others to successfully gain access to and to maintain contact with community resources and services.

3 = Participant needs and/or requests moderate assistance in locating and gaining access to services identified in the treatment of service plan. Participant may require and/or request moderate assistance, often in nontraditional ways, to access, establish, and maintain contact and services with the identified service providers.

5 = Participant is unable and/or unwilling to locate or gain access to services identified in the treatment or service plan. Participant's identified needs are so immense or so unusual that assertive and creative efforts outside of the usual and normal practice must be employed in order to help the person gain the resources and services identified. Participant needs and/or requests significant (frequent and continual) assistance by others to successfully gain access to and to maintain contact with community resources and services.

MONITORING OF SERVICE DELIVERY

The participant gauges and communicates his/her satisfaction with the progress that has been made and with the services offered/delivered by the service providers identified in the treatment plan. The participant suggests possible needed revisions and/or additions to the treatment/service plan. The TCM should recognize that language and culture has much to do with expressions of satisfaction/dissatisfaction and be prepared to assist the participant in suggesting changes in the treatment plan/service plan or actual provider.

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

0 = Participant does not need/or request assistance in this area.

1 = Participant is able to communicate, when encouraged, his/her opinion of the progress and satisfaction with the service provider and/or the delivered services as well as the need for revisions to the treatment/service plan. Participant is able and willing to participate in intra- and inter- agency as well as cross-systems reviews of the need for and appropriateness of the specific services delivered. Minimal assistance from others is needed and/or requested to ensure that the participant is satisfied with the services received.

3 = Participant needs and/or requests moderate assistance in determining and communicating his/her satisfaction with the service provider and with the services delivered. Participant need and/or requests moderate assistance in identifying what progress has been made and the possible need for revisions to the treatment/service plan.

5 = Participant is almost totally dependent on others to see that progress is being made and to suggest needed revisions to the treatment/service plan. Participant needs and/or requests significant assistance to communicate effectively and realistically about his/her progress and satisfaction with the service provider and/or the services delivered.

PROBLEM RESOLUTION

The participant is able to resolve issues and overcome barriers, including those that are cultural and linguistic in nature, that prevents him/her from receiving needed treatment, rehabilitation, and/or support services as well as entitlements. The participant is aware of and able to utilize complaint/grievance procedures as well as additional appropriate advocacy supports. The targeted case manager, when requested and or needed, may be called upon to not only help the participant with these tasks but also to provide information to the County Office of Mental Health and/or the BHMCI in order to overcome barriers and to assist the participant in obtaining needed services.

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

0 = Participant does not need/or request assistance in this area.

1 = Participant needs and/or requests minimal assistance to resolve issues and overcome barriers that prevent him/her from receiving treatment, rehabilitation and/or support services.

3 = Participant is able, with moderate assistance and encouragement, to identify issues that need to be resolved but is unable, without direct assistance from others, to formulate steps or implement actions that would overcome barriers that prevent him/her from receiving treatment, rehabilitation and/or support services.

5 = Participant needs and/or requests significant assistance, to identify and resolve issues that prevent him/her from receiving treatment, rehabilitation and/or support services. Participant is totally dependent on others to recognize and to take steps to overcome these barriers. Resolution may require the intervention of the County Office of Mental Health and/or the modification of existing services or the development of new services.

PHILADELPHIA ENHANCEMENT PILOT
ENVIRONMENTAL MATRIX SCORING GRID

Matrix Level	Need Level	Intensity of Care
5	**Significant**	**2-3 contacts per week (Must be Face to Face)**
4.0 - 4.9	**High**	**1-2 contacts per week (Must be Face to Face)**
3.0 - 3.9	**Moderate**	**Should be preparing for discharge. No longer eligible for Blended Enhanced**
1.5 – 2.9	**Minimum**	**Not eligible for Blended Enhanced**
0 – 1.4	**No TCM Needed**	**Not eligible for Blended Enhanced**

History of Challenging Behaviors

Summary Score Sheet

Date:	
Referral Source:	

Individual: *(Last, First, M.I.)*	**D.O.B**	**Preferred Name:**
Staff Name/Title/Credentials:		**Gender:**

*Challenging Behaviors	Score
1. History of Suicidal Behaviors	
2. Suicidal Ideation	
3. Homicidal Ideation	
4. Aggressive Behavior	
5. Self Injurious Behaviors	
6. Sexual Behaviors	
7. Physical Health Issues	
8. Fire Setting	

*Notify Regional Director of all 4 or 5 scores in above category.

Contributing Factors	Score
9. Medication	
10. Mental and Physical Health Service Use	
11. Basic Non-MH Needs: Housing & Financial	
12. Emergency Service Use	
13. Hospitalization	
14. Support System	
15. Substance Use	
16. Personal Care	
17. Incarceration	

Notes:

Program Name:

Program Director:

Next-Steps

Recommendations / Disposition (To be completed by Regional Director or Psychiatrist for all challenging behavior ratings of 4 and/or 5)

Individual's Name: ______________________________________

D.O.B.__________________

	____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ __________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ___ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ __________ ____________________ ____________________ ____________________ ____________________ _______________

Individual's Name: _____

D.O.B._____

Directions:

Circle the number on each domain that you believe best describes the individual and transfer that value to the History of Challenging Behaviors Summary Score Sheet.

CHALLENGING BEHAVIORS DOMAINS

1. History of Suicidal Behavior (Include gestures):

5	4	3	2	1
High lethality and intent within the last year	High lethality and intent more than one year or moderate lethality and intent ever	Low lethality and intent ever and serious threats of suicide	Gestures of low lethality and frequent threats.	Never

Comments:

***Any history of suicide attempt should be noted and reported to your program director.**

2. Suicidal ideation:

5	4	3	2	1
Severe issues. Current intent, has concrete plan or evidence of a suicide plan within the past 24 hours to 30 days.	Very serious. No current intent but had concrete plan or evidence of a suicide plan within the past 90 days.	Serious. Now expresses vague suicidal thoughts, discussed or had plan in past 2 years.	Chronic or periodic suicide ideation but rare if ever plans or attempts	Never

Comments:

3. Homicidal Ideation*

5	4	3	2	1
Severe issues. Current intent, has concrete plan or evidence of a homicidal plan within the past 24 hours to 30 days.	Very serious. No current intent but had concrete plan or evidence of a homicide within the past 90 days.	Serious. Now expresses vague homicidal thoughts, discussed or had plan in past 2 years.	homicidal ideation more than 2 years ago	Never

Comments:

***Immediately Notify Regional Director or designee for ratings of 4 or 5**

4. Aggressive Behavior:

5	4	3	2	1
Severe issues. Current aggression or there is evidence wants to injure others now or within past 30 days.	Very serious. Aggression recently or said would like to injure someone in the past 30 to 90 days; explosive or uncontrollable behavior or property damage.	Serious. Aggressive behaviors (verbal/physical) within the past 3 months to 2 years; explosive and verbal abuse that is re-directable.	Not serious. Aggressive behaviors (verbal/physical) more than 2 years ago, acting out, verbally abusive. Lack of impulse control.	No issue. No aggressions toward others.

Comments:

5. Self Injurious Behaviors

5	4	3	2	1
Severe Issues. Frequent and unpredictable acts with potentially grave consequences that may cause significant harm within the last 6 months	Serious Issues. Frequent and unpredictable acts with potentially grave consequences that may cause significant harm ever	Serious issues, occasional attempts that require medical intervention or hospitalization	Not Serious. Chronic or periodic superficial cutting, scratching and other behaviors that rarely requires medical attention	Never

Comments:

6. Sexual Behaviors

Individual's Name: _____

D.O.B._____

5	4	3	2	1
Severe Issues. Arrested for sexual misconduct; sexual assaults, sexual acting out in past 6 months or registered under Megan's Law.	Very Serious Issues. Any past history of arrest for sexual assault or abuse	Serious Issues. Public display, voyeurism, sexual touching or acting out with or without legal involvement within the last 2 years	Public display, voyeurism, sexual touching or acting out with or without legal involvement ever	No Issues. No inappropriate sexual behaviors.

Comments:

7. Physical Health Issues

5	4	3	2	1
Severe; Recent Diagnosis of Infection/Disease, onset of symptoms, terminal stages of disease; acute exacerbation.	Serious: or persistent health concerns or symptoms. Near constant risk of decompensation.	Moderate: Some health concerns impact on functioning.	Minor: Health concerns impact slightly on functioning.	No health issues.

Comments:

8. Fire Setting

5	4	3	2	1
Severe issues. Legal involvement for fire setting or arson ever. Is person ever placed on 1:1 status to avoid fire setting or arson	Very Serious. Serious intent , recent verbal threats with hx of fire setting	Serious careless behaviors that increase the risk of accidental fire without intent of harm	Threats or suspicions of fire setting behaviors	Never

Comments:

CONTRIBUTING FACTORS DOMAINS

9. Medication

5	4	3	2	1
Almost never takes medication as prescribed.	Rarely takes medication as prescribed.	Usually takes meds as prescribed.	Nearly always takes meds as prescribed.	Always take meds as prescribed.

Comments:

***Include both psychiatric and medical medications**

10. Mental and Physical Health Service Use: (Non-Medication; Non-Crisis)

5	4	3	2	1
None. Services needed, but not used in past year.	Poor. Misses most appointments, attends less than 50% of time.	Some. Keeps 50% of appointments / attendance.	Fair. Regular attendance, few missed appointments.	Good. 1 year of service use with regular attendance.

Comments:

11. Basic Non- MH Needs: Housing and Financial

5	4	3	2	1
Severe; Homelessness, no financial resources.	Serious; Many residential changes, cannot manage money.	Moderate: Some challenges with housing and finances.	Minor: No housing issues, is generally ok with finances.	Stable Housing and finances, no interference with functioning.

Comments:

12. Emergency Service Use (Police, Fire, Ambulance, ER, CRC)

5	4	3	2	1
Frequent. More than once in past 2 months or 6 times in past year.	Moderate. More than once in past 6 months.	Occasional. More than once a year.	Rare. Once in the past year to 2 years.	Never

Comments:

13. Hospitalization

Individual's Name: _____

D.O.B._____

5	4	3	2	1
Hosp within past 30 days.	Hosp within past 6 months.	Hosp within past 2 years.	Hosp more than 2 years ago.	Never Hospitalized.

Comments:

***Indicate whether it's a medical or psych hospitalization and frequency and length of stay**

14. Support System

5	4	3	2	1
Very inadequate. No family, spouse or friends willing or able to be involved.	Inadequate. Network fragmented or temporarily affected by varied issues, network fragmented or threatened by family crisis	Adequate / Stressed. Network is small, the individual can be overly dependent on 1 person.	Adequate. Occasional stress or friction in network, but not affecting the individual or family functioning.	Very adequate. Both family and friends are involved and supportive

Comments:

15. Substance Use

5	4	3	2	1
Currently addicted to 1 or more substances that seriously impacts functioning within 6 months	Recent addiction and sober for more than 6 months; or sporadic substance use that does not affect functioning	Current use of 1 or more substances and engaged in treatment	Not Very Serious. Current abstinence of 1 year or less, engaged in treatment and/or support groups	No Issue. No history of substance use or current abstinence of 2 years or more, recovery supports in place

Comments (include any withdrawal symptoms and severity):

***Any acute withdrawal symptoms, direct to nearest ER or Assessment Center**

16. Personal Care

5	4	3	2	1
Right now has 4 of the following:	Right now has 3 of the following:	Right now has 2 of the following:	Right now has 1 of the following:	Right now has none of the following:

Please circle all that applies: Body odor, lice, dirty hands or nails, foul breath, dirty or uncombed hair, or very inappropriate dress (e.g. coats in summer or no covering in winter);
or evidence in the past almost never bathed, combed hair, etc., even when asked

Comments:

17. Incarceration*

5	4	3	2	1
Past 24 hours up to 30 days.	From 30 days to 1 year.	From 1 to 2 years.	More than 2 years ago.	Never

Comments Identify offense(s) or indicate if under supervised release, etc. or other implications::

Overall Comments by Evaluator
:_____

_____
_____

_____
_____

_____
_____

_____
_____

***Complete an Incident Report where applicable as outlined in the Incident Management Policy and Procedure P&P 5.11.1

_____ _____

Staff Completing Form Signature Date Supervisor's/Director Signature Date

_____ _____

Individual's Name: _____

D.O.B._____

Regional Director's Signature (if applicable) Date Psychiatrist Signature (if applicable) Date