SHELTER PLUS CARE- CASE PRESENTATION FORM
ALL AREAS MUST BE COMPLETED FOR CASE TO BE CONSIDERED

2014

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Client's Name: _____ **SSN:** _____

Current Address: _____ **D.O.B:** _____

County of last residence: ☐ SLC ☐ IRC ☐ MC ☐ OTHER _____

US Citizen/ Legal Alien: ☐ YES ☐ NO ☐ PENDING

Current living situation/ housing: (with documented verification for eligibility determination)

☐ Non- Housing (street, park, woods, etc.) ☐ Emergency Shelter ☐ Psychiatric Facility

☐ Hospital ☐ Substance Abuse Treatment Facility ☐ Jail/ Prison ☐ Domestic Violence

☐ Living with relatives/ Friends ☐ Other: _____

Current living Situation (Describe in **full detail** client's situation- include information on prior living situation as well): Individual **MUST** meet homeless criteria to be eligible for the program.

_____

☐ Chronically Homeless ☐ Non-Chronically Homeless

HOUSEHOLD RELATIVES/ MEMBERS:

NAME	RELATIONSHIP	DATE OF BIRTH	AGE	LIVES W/ CLIENT
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO

S+C Eligibility Information: Diagnosis/Disability Code/Description- A disabling condition is defined as "a diagnosable substance abuse disorder, serious mental illness or disability, including the co-occurrence of two or more of these conditions". A disabling condition limits an individual's ability to work or perform one or more activities of daily living." Condition must be verified in writing by a physician or licensed mental health professional.

DIAGNOSIS/ DISABILTY: _____

CODE/ DESCRIPTION: _____

1 Chronic- (1) an unaccompanied homeless individual with a disabling condition who has been continuously homeless for a year or more, OR (2) an unaccompanied individual with a disabling condition who has had at least four episodes of homelessness in the past three years."

2 Non- Chronic- A person sleeping in a place not meant for human habitation or in an emergency shelter, or a person in transitional housing for homeless persons.

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☐ **SMI:** Seriously Mentally Ill ☐ **PWOD:** Person with Other Disabilities ☐ **PWA:** Persons with Aids

GROSS INCOME: Gross Monthly

EMPLOYMENT	$	☐ Receiving	☐ Applied	☐ Denied	☐ Not Applicable
VA BENEFITS	$	☐ Receiving	☐ Applied	☐ Denied	☐ Not Applicable
SSI	$	☐ Receiving	☐ Applied	☐ Denied	☐ Not Applicable
SSD	$	☐ Receiving	☐ Applied	☐ Denied	☐ Not Applicable
CHILD SUPPORT	$	☐ Receiving	☐ Applied	☐ Denied	☐ Not Applicable
OTHER: Source	$	☐ Receiving	☐ Applied	☐ Denied	☐ Not Applicable

Total: $ 0.00

ETHNICITY: CHECK ONE

☐ Hispanic ☐ Non- Hispanic

RACE: CHECK ONE

☐ American Indian or Alaskan Native

☐ Asian ☐ White ☐ Black or African American

VETERAN: ☐ YES ☐ NO

- Discharge- Honorable/ under honorable conditions ☐ YES ☐ NO
- War time served ☐ YES ☐ NO
- VA Disability pay ☐ YES ☐ NO
- VA Health Care ☐ YES ☐ NO

VA Retirement Pay ☐ YES ☐ NO

CLIENT'S EMERGENCY CONTACT:

Name: Relationship: Phone:

Name: Relationship: Phone:

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Agency: _____ **Date:** _____

Case Manager: _____ **Phone:** _____

Email: _____

Supervisor: _____ **Phone:** _____

Supervisor's Email: _____

Service Matches: Estimate hours per month usage of each service

DOCUMENTED SERVICES MATCH		HOURS	RATE	TOTAL
AIDS Related Services	(Month)		$100	$ 0.00
Case Management	(Hour)		$80	$ 0.00
Dr. Visits	(Visit)		$125	$ 0.00
Drug/ Drop Services	(Day)		$17	$ 0.00
Individual Therapy	(Hour)		$100	$ 0.00
Injection Clinic	(Shot)		$25	$ 0.00
Life Skills	(Hour)		$39	$ 0.00
Medication Review	(15 MINS)		$80	$ 0.00
Psych Evaluation	(Hour)		$225	$ 0.00
Psych Hospital	(Day)		$400	$ 0.00
Representative Payee Services	(Week)		$10	$ 0.00
Substance Abuse	(AA)		$10	$ 0.00
Therapy (DIALYSIS)	(TX)		$45	$ 0.00
			TOTAL	$ 0.00

Signature of Case Manager: _____

Date: _____

BOARD USE ONLY:

Approved: ☐ YES ☐ NO ☐ FAMILY GRANT ☐ CHRONIC GRANT ☐ NEW GRANT

Denied- Reason: _____

Initials: _____