SOJOURNER
HOUSE

5460 Penn Avenue · Pittsburgh, PA 15206 · (412) 441-7783 (phone) · (412) 441-3409 (fax) · info@sojournerhousepa.org (e-mail) · www.sojournerhousepa.org

Dear Referral Agency:

Thank you for your interest in our supportive housing program, Sojourner House MOMS. Enclosed, you will find a complete packet for you and your participant to fill out.

All applicants must meet the following criteria:

- Must be homeless
- Must be in recovery from addiction (at least 90 days of documented treatment history)
- All units are 3 bedrooms; therefore the client must have a minimum of 2 children
- The head of household may be male or female with custody of at least one child and/or be pregnant
- May have co-occurring disorder (substance abuse and/or mental health)

In order for the referral packet to be considered, the packet must be completed. Below, are instructions for completing the packet and a check list of the required documents that are needed for the packet to be considered completed.

1. Applicant Self Statement
   a. To be completed by applicant
2. Referral Form (5 pages)
   a. To be completed by the therapist/counselor/social worker of the referring agency
3. Consent for the Release of Confidential Information
   a. Person making the referral, please sign as the witness
   b. Please have applicant *initial* “accept or reject” (not a check mark)
4. Letter verifying homelessness
   a. To be completed by the referral agency
5. Letter verifying 90 days treatment attendance
   a. To be completed by the treatment provider

To expedite the application process, please include (if available):

☐ 1. State/government photo ID of applicant
☐ 2. Copies of birth certificates of all members that will be living in the household
☐ 3. Copies of social security cards of all members that will be living in the household
☐ 4. Copies of insurance cards of all members that will be living in the household
☐ 5. The most recent DPW printout (30 days current)

Individuals who inquire on their own behalf will have materials sent to them, but packet completion rests on the provider. All applications will include an Applicant Self Statement, Referral Form (5 pages), and a Consent for the Release of Confidential Information. Completed applications can be faxed to: (412) 451-8104, or emailed to: kupsher@sjhpa.org. Questions should be directed to Karen Upsher, Family Housing Manager, at: (412) 361-1213 ext. 202.

Sincerely,

Karen Upsher
Family Housing Manager

**SOJOURNER HOUSE MOMS**
**SUPPORTIVE HOUSING PROGRAM**

## APPLICANT SELF STATEMENT

**5524 Hays Street**
**Pittsburgh, PA 15206**

**Phone: 412-361-1213**
**Fax: 412-451-8104**

*Please print all information clearly.*

Name______________________________________________ SS# _________________________

1. Why are you applying to Sojourner House MOMS?

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

2. Why do you feel that you are a good candidate for this program?

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

3. What do you believe are your strengths?

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

4. Where do you see yourself in two to three months from now?

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

5. What do you need to have in order to move into permanent housing?

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Signature__________________________________________ Date ____________________

**SOJOURNER HOUSE MOMS**
**SUPPORTIVE HOUSING PROGRAM**

**REFERRAL FORM**

**5524 Hays Street**
**Pittsburgh, PA 15206**

**Phone: 412-361-1213**
**Fax: 412-451-8104**

Sojourner House MOMS is a nondenominational, faith-based, transitional supported housing program that targets homeless individuals affected by co-occurring disability (mental illness and substance abuse). Minimal eligibility also requires evidence of custody of child/children. Please complete *all* items. If an item does not apply, list N/A. This *Referral Form* must be completed and signed by the referring agency. The *Applicant Self Statement* and all required documentation must be included. Incomplete referral packets will not be considered.

**DEMOGRAPHIC/INFORMATION**

Applicant's Last Name: ________________________________ Maiden Name (if different):_________________________

First Name:_______________________________________________ Middle Initial: ____________

DOB: ________________ Age: _________ Sex: ___________ Social Security #:_________________________

U.S. Citizen? : Yes ☐ No ☐ Veteran? : Yes ☐ No ☐

Race: African American ☐ Asian/PI ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other ☐

Current address/place mail and checks are received: ________________________________________________________

________________________________________________________________________________________________

Current Phone Number: ______________________________ Alternate Phone Number: _________________________

Prior Address: _______________________________________City:____________________ State: _______ Zip:________

Emergency Contact Person: _____________________________________________ Phone: ____________________

Other agencies currently involved with applicant: ___________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

Gross Monthly Household Income: _____________________ SS: ____________ SSI: ___________ DPW: ____________

Food Stamps: _________ Wage/Pension: ________ VA: ________ Unemployment: ________ Other: ___________

If employed, name and address of employer and length of employment: ______________________________________

________________________________________________________________________________________________

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## FAMILY

Marital Status: Married ☐ Divorced ☐ Single ☐ Widow ☐ ➔ If married, does individual still maintain a relationship with spouse? ____________________________________________

Does individual have a history of domestic violence? (If yes, please describe): ______________________

____________________________________________

____________________________________________

____________________________________________

Number of children that will be living with the head of household while in program: ______________

*Please complete for the child(ren) that will live with the head of household:*

| Name | Age | Gender | Relationship | Will this child be living in the household full-time? | Does the head of household have legal custody? |
|---|---|---|---|---|---|
| | | M F | | Yes No | Yes No |
| | | M F | | Yes No | Yes No |
| | | M F | | Yes No | Yes No |
| | | M F | | Yes No | Yes No |
| | | M F | | Yes No | Yes No |
| | | M F | | Yes No | Yes No |

Does the individual have long and short-term goals for self and family? No ☐ Yes ☐ (If yes, give brief description):

____________________________________________

____________________________________________

____________________________________________

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## CLINICAL INFORMATION

Please verify diagnoses by one of the following methods: psychiatric evaluation form, clinical notes, outreach assessment form, or any documentation signed by an MD including this referral form.

Diagnosis

Axis I: ______________________________________________________________

Axis II: _____________________________________________________________

Axis III: ____________________________________________________________

Axis V (GAF): ________________________________________________________

Current mental health treatment (includes satisfaction and compliance with treatment): ________________

______________________________________________________________________

______________________________________________________________________

Current MH Provider: ____________________ Phone: _______________ Last Date Seen: ________

Current Medical Issues: _______________________________________________

______________________________________________________________________

______________________________________________________________________

Current Medical Provider: __________________ Phone: _____________ Last Date Seen: ________

Current list of medications and who prescribed (include dosage and times): ______________________

______________________________________________________________________

______________________________________________________________________

Drug and alcohol use/history (include drug of choice and date of last use): ______________________

______________________________________________________________________

______________________________________________________________________

Current D&A Provider: ____________________ Phone: ____________ Last Date Seen: __________

Forensic issues: _________________________________________________________

______________________________________________________________________

______________________________________________________________________

Current clinical status (include symptoms): ___________________________________

______________________________________________________________________

______________________________________________________________________

Signs and symptoms of decompensation (include history of violence, suicidal or homicidal ideation): __________

______________________________________________________________________

______________________________________________________________________

What interventions generally work when this occurs? ______________________________________________

______________________________________________________________________________

______________________________________________________________________________

Does the individual and/or a family member have other special needs that we should be aware of? ___________

______________________________________________________________________________

Does the individual and/or family member who would be living with applicant have a history of violence towards staff? Yes ☐ No ☐ (If yes, please describe): ________________________________________

______________________________________________________________________________

Does the individual need assistance with medication management? Yes ☐ No ☐

With staying in treatment? Yes ☐ No ☐

Additional comments: ______________________________________________________________

______________________________________________________________________________

**HOMELESS INFORMATION**

How long has applicant been homeless? _____________________________________________

Living situation for past 3 months (include current living situation): ______________________________

______________________________________________________________________________

How long can applicant remain at current residence? Why? ___________________________________

______________________________________________________________________________

______________________________________________________________________________

Ideal living situation: ______________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Please list the applicant's current strengths, supports, resources, and accomplishments: ________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

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Please describe the skills, resources and assistance the applicant needs (financial, budgeting, education, housing, employment, health, mental health, recovery, parenting, social support, leisure, household management, etc.):

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Additional comments (please include any housing options that have been explored): ____________________

______________________________________________________________________________

______________________________________________________________________________

Date of referral: ______________________ Agency: ______________________________

Contact person: ______________________________ Phone: ______________________

Please check what additional information is included with this referral form:

- ☐ Psychiatric evaluation form, clinical notes, and/or outreach assessment form
- ☐ Signed and dated statement from staff of transitional housing which describes applicant's homeless status prior to living in transitional setting
- ☐ Copy of eviction notice or written statement from evictor
- ☐ Documented attempts to identify other housing resources (if coming from institution)
- ☐ Verification of financial status
- ☐ Other
- ☐ Applicant self statement