ALLIANCE HEALTHCARE SERVICES

Community Targeted Transitional Support (CTTS) Application

This project is funded under a grant contract with the State of Tennessee, Department of Mental Health and Substance Abuse Services.

Client Name: _____

Referring Agency: _____ **Referring Clinician Name:** _____

Referring Clinician Phone #: _____ **Referring Clinician E-Mail:** _____

Is client compliant with treatment? ☐ **Yes** ☐ **No**

ELIGIBILITY:

Date of Birth: _____ **Age:** _____ **Gender:** ☐ **Male** ☐ **Female**

- *Must be 18 or older unless an emancipated youth*

Race: *(check one)*

☐ **African American** ☐ **White** ☐ **American Indian And Alaska Native** ☐ **Asian** ☐ **Native Hawaiian or other Pacific Islander**

☐ **Some Other Race Alone** ☐ **Two or More Races** ☐ **Unknown**

Ethnicity: ☐ **Hispanic** ☐ **Not of Hispanic Origin** ☐ **Unknown**

Has Insurance ☐ YES ☐ NO

Address _____ **City:** _____ **State:** _____ **Zip:** _____

County: _____ ***Days Homeless – Prior 30 days:** _____

**How many days of homelessness (outside, any place not meant for habitation, shelter, transitional housing) did this client experience in the last 30 days prior to receiving this service.*

Primary Diagnosis: _____ **Secondary Diagnosis:** _____

Does client have severe mental illness? ☐ **Yes** ☐ **No**

Does client have co-occurring disorder (substance abuse AND mental illness)? ☐ **Yes** ☐ **No**

What areas does client have MODERATE, MARKED, OR SEVERE Level of Functional Impairment?
(Based on attached Functional Impairment Document form)

1. **ACTIVITIES OF DAILY LIVING:** ☐ **Yes** ☐ **No**
2. **INTERPERSONAL FUNCTIONING:** ☐ **Yes** ☐ **No**
3. **CONCENTRATION, TASK PERFORMANCE AND PACE:** ☐ **Yes** ☐ **No**
4. **ADAPTATION TO CHANGE:** ☐ **Yes** ☐ **No**

- *Must have at least one yes to be eligible for CTTS assistance*

Has the client ever received CTTS assistance in the past? ☐ **Yes** ☐ **No**

***Including the client, how many people live in the client's household?** _____ **For group home enter "1"*

Please list everyone else in the household (oldest to youngest)

NAME (last name first)	AGE	DATE OF BIRTH	SOCIAL SECURITY NO.	RELATIONSHIP TO CONSUMER

Attach extra page if needed

Does the client's rent include any of the following?
☐ Heat ☐ Electricity ☐ Water ☐ No Utilities included

Monthly Household Budget

INCOME SOURCE	AMOUNT	MONTHLY EXPENSES	AMOUNT
Job		Rent/Mortgage	
Food Stamps		Food/Clothing	
AFDC		Transportation	
Social Security		Loans	
Unemployment		Insurance	
Retirement		Cable &/or Internet	
SSI		Phone	
Child Support		Utilities (light, gas, water)	
Other (specify)		Other (specify)	
Total Monthly Income		**Total Monthly Expenses**	

- *Household income must be at or below current federal poverty level*

If expenses exceed income, what is the plan to prevent future financial crisis?

What factors led to the need for assistance?

How will the client ensure that the situation does not happen again?

What steps will you take to help your client make sure this situation does not happen again?

- ***Grant contract requires documentation of attempt to obtain assistance elsewhere.***

What other forms of assistance have you tried to access? ☐ MIFA ☐ CSA ☐ Other

Agency Contacted: _____ Assistance Amt: _____ If $0, reason: _____

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Describe other efforts to obtain assistance:

Type of Assistance Needed:

☐ Rental Deposit ☐ Rental Supplement ☐ Utility Deposit ☐ Utility Supplement ☐ Dental Care ☐ Eye Care

Amount of Assistance Requested: _____

- Dental or Vision can be submitted in two parts with one application (i.e. initial exam and follow up work)

Supporting documents attached:

- ☐ Copy of Release of Information to appropriate party (MLGW, Landlord, etc.) (original goes in chart)
- ☐ Copy of Past Due Bill or Cutoff Notice for utilities
- ☐ Copy of Lease/Mortgage ***and*** Landlord's Mortgage Company's statement of Rent/Payment Past Due
- ☐ Copy of Marriage License ***if*** Lease/Mortgage or Utility Bill is in spouse's name
- ☐ Dental Treatment Plan for initial visit cost or follow up service
- ☐ Vision Treatment Plan for initial visit cost or follow up service

Payment Outcome: (Select One)

- ☐ **Maintain current housing**
- ☐ **Secure house** (consumer moves into new housing)
- ☐ **Maintain/Health** (eye or dental care provided to support independent housing)
- ☐ **Secure/Health** (eye or dental care provided to support acquisition of successful independent housing)

I, _____, attest that the above information is complete and accurate. I understand that this

Consumer's Printed Name

application is not a guarantee of assistance and said assistance is dependent on available monies, conditions of compliance with treatment, length of treatment, substance abuse free status, number and dates of past assistance.

_____ _____

Consumer's Signature Date

I, _____, attest that I have completed this application with the above consumer in a face to

Clinician's Printed Name

face session and believe the above information to be thorough and complete, to include necessary cut off or eviction notices. I have also copied this form for placement in consumer's medical record upon submission

_____ _____

Clinician's Signature Date

If this application approval is a result of waiving agency guidelines, please submit supervisory approval with justification of documentation (email, medical record, etc.).

FOR OFFICE USE ONLY

☐ ***Denied – Ineligible***

☐ ***Approved***

Most Recent Previous Assistance:	

Amount Authorized: ***$*** _____ ***Signature:*** _____ ***Date:*** _____

SUBMIT COMPLETED FORM TO ALICE THOMPSON

_____

Date Received:

FUNCTIONAL IMPAIRMENT DOCUMENTATION FORM

Client Name: _____ **Case Number:** _____

Focus on the consumer's **LOWEST** level of functioning during the past **one year** and use the following functional impairment scales to describe the level of impairment **due to mental illness**. Please specify/describe any moderate, marked, severe score.

1. **ACTIVITIES OF DAILY LIVING:** Include activities such as cleaning, shopping, taking public transportation, Paying bills, maintaining a residence, grooming and hygiene, using telephones and directories, using a post office, etc. Also taken into account is the individual's independence, appropriateness, and effectiveness in executing these skills, as well as the ability to initiate and participate in such activities without supervision or direction. Suicidal Behavior is also included here.

   ☐ **EXTREME**- Unable to perform any daily routine activities and requires constant assistance in most areas. Extreme dysfunction in this area may cause marked dysfunction in other areas. *Describe* Specific problems client is having in this area of functioning:

   _____

   ☐ **MARKED**- Has regular or frequent problems with performing daily routine activities and is unable to perform up to acceptable standards without frequent assistance. *Describe* Specific problems client is having in this area of functioning:

   _____

   ☐ **MODERATE**- Has regular or frequent problems with performing daily routine activities and is unable to perform up to acceptable standards without frequent assistance. *Describe* Specific problems client is having in this area of functioning:

   _____

   ☐ **MILD**- Has some or occasional problems with performing daily routine activities and could benefit from some assistance. *Describe* Specific problems client is having in this area of functioning.

   _____

   ☐ **NONE**- Has no problem performing daily routine activities without assistance. If problems do exist they are not due to a mental illness. *Describe* Specific problems client is having in this area of functioning:

2. **INTERPERSONAL FUNCTIONING:** Capacity to interact appropriately and communicate effectively with others and get along with family and community. Deficits are reflected in history of altercations, evictions or firings, fear of strangers, avoidance of interpersonal relationships and social isolation. Strengths are reflected in ability to initiate social contact and to participate actively in groups, cooperative behavior, and consideration of and sensitivity to other people's feelings.

   ☐ **EXTREME**- Isolated in the community, has no support network and/or no ability to take part in social activities or self manage in relationships with others and/or demonstrates extreme aggression with inability to control behavior. *Describe* Specific problems client is having in this area of functioning:

   _____

   ☐ **MARKED**- Isolated in the community; uses agency staff or program for social support and/or has substantial support and/or has substantial impairment in the ability to take part in social activities or self manage in relationships with others and/or demonstrates aggressive episodes but can control behavior with assistance. *Describe* Specific problems client is having in this area of functioning:

   _____

   ☐ **MODERATE**- Limited integration in the community; little or no use of natural supports and/or marginal capacity to take part in a variety of social activities or manage self in relationship to others and/or demonstrates aggressive episodes with limited ability to self manage behavior. *Describe* Specific problems client is having in this area of functioning:

   _____

☐ **MILD**- Partial integration into community life uses natural supports and/or participates in appropriate interacting with others within expected social development, and cultural norms when engaged in/or demonstrates aggressive episodes with ability to self manage behavior. *Describe* Specific problems client is having in this area of functioning:

☐ **NONE**- Full integration into community life; uses natural supports and/or initiates appropriate interaction with others within expected social, developmental, and cultural norms and/or asserts self appropriately. *Describe* Specific problems client is having in this area of functioning.

3. **CONCENTRATION, TASK PERFORMANCE AND PACE:** Ability to sustain focused attention for long enough time to permit the completion of tasks commonly found in work settings or other structured situations in school and home. Deficits are reflected in ability to concentrate and/or complete simple tasks within required time, committing frequent errors, or requiring assistance in completing such tasks.

☐ **EXTREME** – Unable to complete simple tasks. *Describe* Specific problems client is having in this area of functioning:

☐ **MARKED** – Seldom able to concentrate and has extensive difficulty completing simple tasks without assistance. *Describe* Specific problems client is having in this area of functioning:

☐ **MODERATE** – Regular or frequent difficulty with concentration and can complete simple tasks within timeframes and/but needs prompting and help. *Describe* Specific problems client is having in this area of functioning.

☐ **MILD** – Some or occasional difficulty with the ability to concentrate and can complete simple tasks within timeframes with few errors and with some assistance. *Describe* Specific problems client is having in this area of functioning.

☐ **NONE** – Has ability to concentrate and can complete simple tasks within set timeframes with few errors and without assistance. *Describe* Specific problems client is having in this area of functioning.

4. **ADAPTATION TO CHANGE:** Ability to cope with stressful circumstances associated with work, school, family, or social interaction. Deficits are reflected when any unexpected environmental change causes agitation, exacerbation of signs and symptoms associated with the illness, or withdrawal from the stressful situation.

☐ **EXTREME** – No tolerance for any changes; negative reaction may cause marked dysfunction in other areas. *Describe* Specific problems client is having in this area of functioning.

☐ **MARKED-** Extensive difficulty in adjusting to change; will require a significant amount of intervention. *Describe* Specific problems client is having in this area of functioning:

☐ **MODERATE**- Regular or frequent difficulty in accepting and adjusting to change; adaptation will require some intervention. *Describe* Specific problems client is having in this area of functioning:

☐ **MILD-** Some or occasional difficulty in accepting and adjusting to change; may need minimal support. *Describe* Specific problems client is having in this area of functioning.

☐ **NONE-** Able to reasonably adapt to change within developmental and cultural norms. *Describe* Specific problems client is having in this area of functioning.