Southern Maryland Community Network, Inc.
Mental Health Housing Stabilization Program
The Porter House

P.O. Box 998 Prince Frederick, MD 20678
(410) 535-4892 (office) (410) 495-8400 (fax)
(443) 432-3893 (office) (443) 486-5740 (fax)

Referral Application

Date of Application:_______________

Name:____ Age:________ Date of Birth:____________

Sex: ☐M ☐F ☐Other If other, please explain____

Social Security #:__________________________

Address:_______________________________________ County of Residence:_______________________

City/State/Zip:____________________________________ Phone:________________________________

Psychiatrist:______________________________________ Phone:________________________________

Address:_______________________________________ City/State/Zip:_____________________________

Therapist:_______________________________________ Phone:________________________________

Address:_______________________________________ City/State/Zip:_____________________________

REFERRAL SOURCE:

Name:____ Title:___________________________________

Organization:____________________________________ Phone:_________________________________

Address:____ City/State/Zip:____________________________

Emergency Contact Person Information:

Name:_____________________________ Relationship to Consumer:_________________________

Address:__________________________________ Phone:__________________________________

City/State/Zip:____

FINANCIAL STATUS:

Medical Assistance [ ] M.A. #____________________ Medicare [ ] M.C. #________________________

[ ] SSI [ ] SSDI [ ] TDAP [ ] Food stamps [ ] Open SOAR case

Earned Income [ ] Source:_______________________ Other Benefits [ ] Specify:___________________

If unemployed, willing or able to work? [ ] Yes [ ] No

Eligibility for Housing Stabilization Services:

1. [ ] Is homeless or at risk of homelessness.
2. [ ] Has stated a willingness to comply with rules and treatment recommendations.
3. [ ] Able to care for physical and basic hygiene.
4. [ ] Must have a psychiatric diagnosis. DSM V Diagnosis:________________________________
5. [ ] Must be able to self-administer medications.

Risk for Homeless-Check all that apply:

1. [ ] Homeless (e.g. lives outside, in vehicle, DV shelter, homeless shelter, transitional housing program).
2. [ ] Mental Health symptoms are so severe they impact the individual's ability to maintain employment, benefits, paying bills, rent and utilities that then jeopardizes housing.
3. [ ] Negative interactions with neighbors, other tenants, or property management staff such as complaints, evictions that jeopardize housing.
4. [ ] Current housing is unsafe to return to (unsafe, unsanitary, experiencing domestic violence).
5. [ ] Unstable housing situation (living with friends/family in emergency short-term housing), motel paid for by self, hospital, returning from jail/prison, other:____________________________________.
6. [ ] Is in an unstable housing situation (living with others in short-term housing), motel, hospital, returning from jail/prison.
7. [ ] Other:____

Consumer's Authorization:

I hereby request SMCN's Mental Health Housing Stabilization Services and understand and am willing to participate. I have read and will comply with the rules.

______________________________________ ____________
Consumer Signature Date

______________________________________ ____________
Signature with Credential Date
Must be Masters Level Licensed Clinician or above

Name:______________________________________ DOB: ____________

Screening Assessment

Name: ____ **DOB:** __________________ **Date:**____________

Presenting problem and or needs:
____
____
____

Diagnosis (DSM V with code):____

Rationale for diagnosis: ____
____
____

Mental Health Risk Assessment (check all that apply):

[ ] Current risk of harm to self, if yes [ ] Ideation only [ ] Intent [ ] Plan and/or [ ] Means

History of suicidal or self-harming behaviors? [ ]Yes [ ] No, if yes please explain:____________________________
____
____

[ ] Current risk of harm to others, if yes [ ] Ideation only [ ] Intent [ ] Plan and/or [ ] Means

History of homicidal or assaultive behavior? [ ] Yes [ ] No, if yes please explain:____________________________
____
____

Is this person at risk of abuse or victimization? [ ] Yes [ ] No, if yes please explain:____________________________
____
____

Elopement risk? [ ] Yes [ ] No, if yes please explain:____
____
____

Mental Status:

General Appearance:

[ ] Well Nourished [ ] Thin [ ] Obese [ ] Casually Dressed [ ] Inappropriate Clothes [ ] Clean
[ ] Well Groomed [ ] Unkempt/Disheveled

Attitude toward Examiner:

[ ] Cooperative [ ] Uncooperative [ ] Guarded [ ] Suspicious [ ] Demanding [ ] Hostile [ ] Impulsive
[ ] Intrusive [ ] Evasive [ ] Negativistic [ ]Manipulative [ ] Poor Boundaries [ ] Threatening Behavior
[ ] Verbally Abusive

Mood:

[ ] Depressed [ ] Dysphoric [ ] Euphoric [ ] Anxious [ ] Irritable [ ] Agitated[ ] Angry [ ] Frustrated
[ ] Sad [ ] Grieving [ ] Reporting no feeling

Affect:

[ ] Appropriate [ ] Inappropriate [ ] Normal [ ] Restricted [ ] Blunted [ ] Flat [ ] Labile [ ] Elated

Thought Process:

[ ] Goal Directed [ ] Looseness of Associations [ ] Tangential [ ] Circumstantial [ ] Flight of ideas
[ ] Word Salad [ ] Perseveration

Thought Content:
[ ] Guilt [ ] Hopeless [ ] Worthless [ ] Helpless [ ] Self Blame [ ] Obsessions [ ] Compulsions
[ ] Agoraphobia [ ] Other Phobia____________________________

Delusions:
[ ] Denies [ ] Paranoid [ ] Grandiose [ ] Derogatory [ ] Somatic [ ] Being Controlled [ ]Bizarre [ ] Fixed, Long Standing, not Interfering with Functioning[ ] Fixed, Interfering with Functioning

Hallucinations:
[ ] Denies [ ] Auditory [ ] Visual [ ] Tactile [ ] Olfactory

Describe content of hallucinations:____
____

Cognitive Functions:

Orientation-	[ ] Person [ ] Place [ ] Time [ ] Circumstances
Memory-	[ ] Intact [ ] Impaired
Concentration-	[ ] Intact [ ] Impaired
Estimate of Intelligence	[ ] Below [ ] Average [ ] Above Average
Insight-	[ ] Poor [ ] Limited [ ] Fair [ ] Good [ ] Excellent
Judgment	[ ] Poor [ ] Limited [ ] Intact

Substance Use/Abuse:

[ ] Nicotine [ ] Alcohol [ ] Marijuana [ ] Amphetamines
[ ] Hallucinogens [ ] Cocaine/Crack [ ] Heroin [ ] Narcotics [ ] Abuse of Prescription Medications [ ] Other____

Please describe history of addictions/ abuse of any of the above:______________________________________
____
____

Strengths:
[ ] Insight [ ] Motivated [ ] Relationship with Therapist [ ] Employed [ ] Financial Stability [ ] Educational Achievement [ ] Stable Health [ ] Stable Relationship [ ] Recreational and Social Involvement [ ] Community Agency/Church/Spiritual/School Involvement [ ] Strong Cultural Identification/Attachment
Other____

Barriers:
[ ] Non-adherence [ ] Lack of Social [ ] Chronic Mental Illness [ ] Financial [ ] Chemical Dependence
[ ] Inconsistent Outpatient Care [ ] Other
____

Family/Natural Supports Strengths and Needs:____
____
____

What would the individual like to accomplish while in The MHHS Program?____________________________
____

What are the Individual's expectations of MHHS services? ____
____
____

Current Medications, Frequency, and Dosage:

Medication	Frequency	Dosage

Mutually agreed upon Treatment Strategies:

☐ Assistance with medication compliance.

☐ Linkage to community resources, including appropriate housing, entitlements/ benefits and behavioral health treatment.

☐ Encourage to utilize natural supports.

☐ Encourage socialization with peers and staff

☐ Provide a safe and structured environment

☐ Assist with developing Coping Skills

☐ Assistance with reality testing

☐ Provide reassurance and encouragement to reduce anxiety fearfulness, anger, etc.

.☐ Confront maladaptive behaviors

☐ Utilize the Crisis Prevention and Response Plan or verbal or written contracts to promote positive behaviors.

☐ Reminders regarding personal hygiene.

☐ Assistance with Money Management

☐ Coach on Housing Maintenance Skills

☐ Other: ____

Please check recommended services

☐ Psychiatrist ☐Crisis Intervention Program ☐ Outpatient Therapy ☐Partial Hospital
☐Psychiatric Rehabilitation ☐Residential Rehabilitation ☐Substance Abuse Tx (outpt) ☐AA/NA

☐Other support group ____
☐ Internal Medicine Physician ☐ Adult Protective Services ☐ Adult Day Care ☐ Medical Equipment
☐ Office on Aging ☐Targeted Case Mgmt. ☐ Spiritual Counseling ☐ ARC
☐ SSI/SSDI ☐SOAR ☐ Supported Employment ☐ DSS
☐ MA/MCHIPS ☐Meals on Wheels ☐ Assisted Living ☐ Geriatric Evaluation
☐ Home Health Services ☐ Bereavement Services
☐ Path Program (Charles County residents only)

LEVEL OF CARE (all care is 24 hour awake):

Please check one:

a) ☐ Staff supervision with no outside activities.
b) ☐ Staff supervised outside activities.
c) ☐ Outings with Case Manager or Agency Provider.
d) ☐ May participate in outings/activities independently (ie: school, work, groups, IOP, and other programming as approved Licensed Mental Health Practitioner/Physician

Diet (Please check):

☐Normal ☐Diabetic Diet ☐Low-fat/Calorie Restricted _____________ calories

Food Allergies/Other: ____

I attest that this individual is willing to participate in and would benefit from Mental Health Housing Stabilization Services:

____

☐ Licensed Mental Health Professional

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Assessment of General Physical Health Form

I, ____conclude upon reviewing the record and/or
(Name of Health Care Professional)

speaking with __________________________________that this individual appears: (Consumer Name)

(Please select the appropriate health care status that applies)

A. ☐ Good physical health

B. ☐ Requires a physical exam

C. ☐ Requires a follow-up with somatic care

If you chose B or C please explain:____

____

D.☐ Is the patient currently being treated for any somatic concerns if so please explain:

____

____

E. Please list any somatic medications if any, including frequency and dosage:

_____________________________________ _______________________
Signature of Health Care Professional Date

The Porter House Rules and Regulations
Please review with all potential referrals before referring and assure that they sign in agreement with abiding by these prior to sending a referral to us.

Welcome to the Porter House Mental Health Housing Stabilization program. The following list of house procedures will help ensure that your time at the house proceeds smoothly and results in the best possible outcome. Thank you for taking a moment to review these and ask any questions you might have.

GENERAL

1. VISITORS: No visitors are allowed at The Porter House.
2. Belongings will be searched upon admission, at discharge and if there are items missing in the house.
3. Persons served must manage personal hygiene and keep their space clean.
4. Persons served MAY NOT be in one another's room.
5. Persons served are expected to complete chores as requested during their stay.
6. Belongings: Please secure your personal belongings. Staff are not responsible for these items. If you have items of value they may be secured by staff upon your request and signed out as necessary. An inventory of these items will be kept and signed off on by yourself and MHHS staff.
6. PHONE: Phone calls may be made and received until 9pm unless there is an emergency. Please limit phone calls to 10 minutes. Only long distance calls pertaining to treatment will be allowed.
7. QUIET HOURS: Persons served are expected to stay in their room from 11pm to 6am Sunday-Thursday and 12am-6am Friday and Saturday.
8. Persons served are expected to be fully and modestly dressed at all times in public areas.
9. Alcohol and illegal drugs are prohibited.
10. Persons admitted to the Porter House MAY ONLY go on personal outings independently when the clinician has signed off on the Independent Level of Care. (ie: school, work, IOP, PRP group, other programming approved by clinician).
11. DISCHARGE: Any personal items or medications left behind after discharge will be disposed of in 30 days.
12. No personal vehicles permitted at The Porter House.

FOOD/KITCHEN

1. HOURS: 6am-9pm, drinks only after 9pm (exceptions approved by staff).
2. MENU: The posted menu, dietician approved, should be adhered to but you may also purchase your own food. You will need to put your name on the packaging of your food and space will be provided for storage of such. Please inform staff if you have food allergies or other special dietary needs.

SERVICES/TREATMENT

1. MEDICATION MONITORING: All medications will be stored and monitored by staff.
2. MEDICATION MONITORIING: Medications without a prescription are prohibited.
3. TRANSPORTATION: Transportation will be provided to Psychiatric, Medical, Substance Abuse and other appointments identified in the treatment plan. Transportation MAY be provided at staff discretion to buy cigarettes but this is not guaranteed.

PERSONS SERVED

1. Persons served shall speak with respect to others AT ALL TIMES.
2. Sexual remarks and foul language is PROHIBITED.
3. Sexual or physical contact with others is not allowed.
4. Respect the privacy of others while they are changing or using the bathroom. KNOCK first.
4. Physical aggression is not allowed.
5. You will maintain the confidentiality of persons served AT ALL TIMES.

STAFF & STAFF AREAS

1. Staff areas will be used ONLY to conduct services that require privacy. Persons served may only enter these areas when asked to do so by staff.
2. Staff direct treatment and safety including, but not limited to, directing appointments, room assignments, safety rules, use and behavior expected in vehicles, chores etc.... It is expected that persons served FOLLOW STAFF INSTRUCTIONS for their safety and that of others in the program.

POSSIBLE GROUNDS FOR IMMEDIATE DISCHARGE

Behaviors that may present a danger to self or others are grounds for immediate discharge. These include, but are not limited to, the following:

1. Leaving The Porter House grounds without staff permission.
2. Use or possession of alcohol or illegal drugs on or off the premises.
3. Possession of weapons or instruments that may be used as weapons.
4. Destruction of property.
5. Theft (on or off Crisis property).
6. Sexual or physical contact.
7. Verbal abuse or threats towards staff or persons served.
8. Aggressive behaviors.

I have read and understand the above procedures. I understand that these are to protect my safety and that of others in the Crisis House. I understand that the program is voluntary and I may discharge at my request at any time.

___________________________ ___________________________

Consumer's Signature **Date**

___________________________ ___________________________

Staff **Date**

This information has been disclosed to you from records protected by federal regulations governing Confidentiality of the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Pts 160 & 164. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by federal regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

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