CHECK LIST FOR REFERRALS

1. Referral Source Contact/Client Information
    a. Armed Forces –
2. Is detox needed? If marked yes, is there a plan indicated?
    a. Drug: _____
3. Legal Items
4. AUTHORIZATION TO RELEASE INFORMATION TO/FROM (if on probation/parole is there an ROI to/from the P.O. as well as referral agency)
    a. Are they witnessed?
5. Applicant Screening Request
6. Brief Description, including Housing Status/History of Homelessness
7. Personal Property Acknowledgement Form
8. Reintegration Plan
9. SOCRATES 8A
10. SOCRATES 8D
11. SOCRATES Scoring Page
12. Mental Health Screening Form III (MHSF-III)
13. CAGE-AID
14. Self-Report Intake History
15. Physical from Provider
16. Can they get a supply of 60 days of medications?
17. TB Verification Must Be Within 30 Days of Admission
18. Medical Information Letter Staff Signed? _____
19. Resident Selection Criteria Staff Signed? _____
20. Benefits Form

Referral to Ft Lyon. Please fax to 719 456 0109 or email to

fortlyonreferrals@coloradocoalition.org

ALL QUESTIONS/FORMS MUST BE COMPLETED.

Name of Referral Source: _____

Phone: _____ Email Address: _____

How long have you, the referral source, known this individual? _____

Name of referral agency: _____

Today's Date: _____

Client Information

Client Name: _____

How long have you been in Colorado? _____

DOB: _____ Gender: _____

Have your served in the Armed Forces? _____

Is Detox needed? _____If yes, what is the detox plan? _____

Previous Substance Abuse Treatment? Yes___ No___ Where:_____

Substance(s) used: _____ Last Use: _____
Type of use: IV SMK SNT ING _____

Mental Health Diagnosis: Yes ___ No ___ Current Diagnosis? _____

Where are they receiving treatment? _____

Benefits: Medicaid___ Medicare_____ SSI____ SSDI ___ AND____ OAP ___ VA ___

Verification of Benefits? Yes _____ No _____

Any open court or warrants? Yes_____ No ____ **Must be closed before admission**

Currently on parole or probation? Yes___ No___ If yes, please include a release of information for us to speak with the Officer.

Emergency Contact for Client: Name _____

Phone:_____

Highest level of education completed: _____

MRN: _____ revised 12/1/17
Provider: _____

Authorization to Request / Release Information

Client Name: _____ Client Date of Birth: _____ Last 4 of SSN: _____

I authorize that information may be exchanged between the following:

Colorado Coalition for the Homeless
Attn Program: **Fort Lyon**
Address: **30999 CoRd 15**
City, State Zip: **Las Animas, CO 81054**
Phone Number: **719 662 1100**
Fax Number: **719 456 0109**

Name or Organization Name: _____
Relationship to Client: _____
Address: _____
City, State Zip: _____
Phone Number: _____
Fax Number: _____

Information to be released (please initial items below to be released):

Information from Medical Programs:

___ Medical Provider Notes ___ Imaging/X-rays ____Consultant Reports ____Operative Reports
____Lab Results ____ Immunizations ____Medication List ____ ER Reports
____ Hospital Admit/Discharge Summaries ____ AIDS/HIV Information ____Dental Records
____ Billing Records ___ Demographic/Face Sheet ____ Other: _____

Information from Mental Health Programs:

____ Lab Results ____ Progress Notes ___ Medication History ___Treatment Plan ___Diagnoses
____ Psychiatric Visit Notes ____ Discharge Summary ___ Treatment Status ___ Intake & Assessment

Information from Substance Treatment Programs:

____ Substance Use Diagnosis ____ Substance Use Progress Notes ____ Substance Use Lab Results
____ Substance Use Discharge Summary ____ Substance Use Clinical Assessments
____ Substance Use Treatment Status ____ Substance Use Treatment Plan

Information from Housing/Case Management Programs:

____ Family/Social Composition ___ Voucher/Lease Information ____Program Status ___Benefit Information
____ Case Notes/Case Management Notes ____ Other: _____
____ All My Records _____ Specific Dates of Service: _____ Electronic Copy

Please indicate the purpose of this release (check all that apply)

____ Continuity of Care ___Insurance ____ Obtain Benefits
____ Legal ___Worker's Compensation ____ Referral
___ Obtain/ Maintain Housing ___ Personal/Other_____

Authorization

I understand that:

- Due to the integrated care provided by the Colorado Coalition for the Homeless information released may include a diagnosis or reference to the following condition(s): behavioral health /psychiatric care; acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV); or substance use disorders.
- Individuals enrolled in our licensed Substance Treatment teams have their substance-specific records protected by 42CFR Part 2. Further disclosure of this information are prohibited unless further disclosure is expressly permitted by the written consent of whom it pertains or as otherwise permitted by 42CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.
- I understand that I may revoke this authorization at any time (except to the extent that the action has been taken to comply with it).
- If I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected by the HIPAA Privacy Rule.

Expiration

I understand that this release expires on: _____ (not to exceed two years from today's date)

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Personal Representative Printed Name Relationship to Patient

_____ _____
Witness Date

RENTAL SERVICES, INC

PH: (303) 420 1212 PH: (800) 628 6414 FAX
(303) 420 1477 FAX (800) 296 9902

NO ONE CHECKS THEM CLOSER!

Applicant Screening Request
Administrative Information
This information is required to process this application.

Rental Services Customer: Colorado Coalition for the Homeless
Department: Ft Lyon
Contact Name: Referral Liaison
Phone: 719 662 1162
FAX: 719 456 0109
Alternate contact: Lisa Trigilio - Program Director Phone 719 662 1111

Type of Report Requested – please check one:

{ } Eviction and Credit Only
{ } Eviction and Credit Plus National Criminal Check

{X} Denver General Sessions

{X} National criminal only

{X} CO criminal courts

{X} CBI

FULL LEGAL NAME:_____ **DOB:**_____ **FULL SS #:**_____

ADDRESS: _____ **CITY:**_____ **STATE:**_____ **ZIP:**_____

APPLICANT'S CONTACT #:_____ **AlT #:**_____

Co-Applicant:_____ **DOB:**_____ **FULL SS #:**_____

ADDRESS: _____ **CITY:**_____ **STATE:**_____ **ZIP:**_____

Co-APPLICANT'S CONTACT #:_____ **AlT #:**_____

I declared that the statements above are true and correct. I authorize verification of my references and credit as they relate to my tenancy AND to future rent collections.

Date:_____ **Signed:**_____ **Co-Signed:**_____

History of Homelessness

Please describe Client's current situation, including their housing status:

When was client's first experience with homelessness? _____

Please describe where client has stayed for the last three years (example-2016-2019). Streets, shelter, detox, jail, hospital. Include **Place names**. Please include names of staff at ANY of these places that might remember them.

Personal Property

1. At admission, Ft. Lyon will only transport 40 pounds of property in one bag per resident. You are also allowed one small purse/bag on you lap.

2. Residents are responsible for the security of their personal belongings during their stay at Fort Lyon.

3. Residents are expected to take all personal belongings with them upon their departure from the campus on or before their discharge date. Ft. Lyon will transport up to 60 pounds of property. If resident is unable to take all property with them:
   i. The inventory will be placed in storage for no more than 30 days.

   ii. It is the resident's responsibility to collect inventory within 30 days; and

   iii. After thirty days, the items will be recycled into the community via the warehouse.

I acknowledge my understanding of the policy above.

_____
Resident Printed Name

_____ _____
Resident Signature Date

_____ _____
Witness

Reintegration Plan

Name:_____ **Date:**_____

Anticipated length of stay at Fort Lyon:

What are your plans upon return to your community in the following areas:

Housing:

Relapse Prevention:

Substance use:

Mental Health:

Medical:

Support system:

SOCRATES

The Stages of Change Readiness and Treatment Eagerness Scale

SOCRATES is an experimental instrument designed to assess readiness for change in alcohol abusers. The instrument yields three factorially-derived scale scores: Recognition (Re), Ambivalence (Am), and Taking Steps (Ts). It is a public domain instrument and may be used without special permission.

Answers are to be recorded directly on the questionnaire form. Scoring is accomplished by transferring to the SOCRATES Scoring Form the numbers circled by the respondent for each item. The sum of each column yields the three scale scores. Data entry screens and scoring routines are available.

These instruments are provided for research uses only. Version 8 is a reduced 19-item scale based on factor analyses with prior versions. The shorter form was developed using the items that most strongly marked each factor. The 19-item scale scores are highly related to the longer (39 item) scale for Recognition ($r = .96$), Taking Steps (.94), and Ambivalence (.88). We therefore currently recommend using the 19-item Version 8 instrument.

Psychometric analyses revealed the following psychometric characteristics of the 19-item SOCRATES:

	Cronbach Alpha	Test-retest Reliability Intraclass	Pearson
Ambivalence	.60 - .88	.82	.83
Recognition	.85 - .95	.88	.94
Taking Steps	.83 - .96	.91	.93

Various other forms of the SOCRATES have been developed. These will be migrated into shorter 8.0 versions as psychometric studies are completed. They are:

8D	19-item drug/alcohol questionnaire for clients
7A-SO-M	32-item alcohol questionnaire for significant others of males
7A-SO-F	32-item alcohol questionnaire for SOs of females
7D-SO-F	32-item drug/alcohol questionnaire for SOs of females
7D-SO-M	32-item drug/alcohol questionnaire for SOs of males

The parallel SO forms are designed to assess the motivation for change of significant others (not collateral estimates of clients' motivation). The SO forms lack a Maintenance scale, and therefore are 32 items in length.

Prochaska and DiClemente have developed a more general stages of change measure known as the University of Rhode Island Change Assessment (URICA). The SOCRATES differs from the URICA in that SOCRATES poses questions specifically about alcohol or other drug use, whereas URICA asks about the client's "problem" and change in a more general manner.

Source Citation:

Miller, W. R., & Tonigan, J. S. (1996). Assessing drinkers' motivation for change: The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES). *Psychology of Addictive Behaviors* 10, 81-89.

Personal Drinking Questionnaire
(SOCRATES 8A)

INSTRUCTIONS: Please read the following statements carefully. Each one describes a way that you might (or might not) feel *about your drinking*. For each statement, circle one number from 1 to 5, to indicate how much you agree or disagree with it *right now*. Please circle one and only one number for every statement.

	NO! Strongly Disagree	No Disagree	? Undecided or Unsure	Yes Agree	YES! Strongly Agree
1. I really want to make changes in my drinking.	1	2	3	4	5
2. Sometimes I wonder if I am an alcoholic.	1	2	3	4	5
3. If I don't change my drinking soon, my problems are going to get worse.	1	2	3	4	5
4. I have already started making some changes in my drinking.	1	2	3	4	5
5. I was drinking too much at one time, but I've managed to change my drinking.	1	2	3	4	5
6. Sometimes I wonder if my drinking is hurting other people.	1	2	3	4	5
7. I am a problem drinker.	1	2	3	4	5
8. I'm not just thinking about changing my drinking, I'm already doing something about it.	1	2	3	4	5
9. I have already changed my drinking, and I am looking for ways to keep from slipping back to my old pattern.	1	2	3	4	5
10. I have serious problems with drinking.	1	2	3	4	5

	NO! Strongly Disagree	No Disagree	? Undecided or Unsure	Yes Agree	YES! Strongly Agree
11. Sometimes I wonder if I am in control of my drinking.	1	2	3	4	5
12. My drinking is causing a lot of harm.	1	2	3	4	5
13. I am actively doing things now to cut down or stop drinking.	1	2	3	4	5
14. I want help to keep from going back to the drinking problems that I had before.	1	2	3	4	5
15. I know that I have a drinking problem.	1	2	3	4	5
16. There are times when I wonder if I drink too much.	1	2	3	4	5
17. I am an alcoholic.	1	2	3	4	5
18. I am working hard to change my drinking.	1	2	3	4	5
19. I have made some changes in my drinking, and I want some help to keep from going back to the way I used to drink.	1	2	3	4	5

Personal Drug Use Questionnaire
(SOCRATES 8D)

INSTRUCTIONS: Please read the following statements carefully. Each one describes a way that you might (or might not) feel *about your drug use.* For each statement, circle one number from 1 to 5, to indicate how much you agree or disagree with it *right now.* Please circle one and only one number for every statement.

	NO! Strongly Disagree	No Disagree	? Undecided or Unsure	Yes Agree	YES! Strongly Agree
1. I really want to make changes in my use of drugs.	1	2	3	4	5
2. Sometimes I wonder if I am an addict.	1	2	3	4	5
3. If I don't change my drug use soon, my problems are going to get worse.	1	2	3	4	5
4. I have already started making some changes in my use of drugs.	1	2	3	4	5
5. I was using drugs too much at one time, but I've managed to change that.	1	2	3	4	5
6. Sometimes I wonder if my drug use is hurting other people.	1	2	3	4	5
7. I have a drug problem.	1	2	3	4	5
8. I'm not just thinking about changing my drug use, I'm already doing something about it.	1	2	3	4	5
9. I have already changed my drug use, and I am looking for ways to keep from slipping back to my old pattern.	1	2	3	4	5
10. I have serious problems with drugs.	1	2	3	4	5

	NO! Strongly Disagree	No Disagree	? Undecided or Unsure	Yes Agree	YES! Strongly Agree
11. Sometimes I wonder if I am in control of my drug use.	1	2	3	4	5
12. My drug use is causing a lot of harm.	1	2	3	4	5
13. I am actively doing things now to cut down or stop my use of drugs.	1	2	3	4	5
14. I want help to keep from going back to the drug problems that I had before.	1	2	3	4	5
15. I know that I have a drug problem.	1	2	3	4	5
16. There are times when I wonder if I use drugs too much.	1	2	3	4	5
17. I am a drug addict.	1	2	3	4	5
18. I am working hard to change my drug use.	1	2	3	4	5
19. I have made some changes in my drug use, and I want some help to keep from going back to the way I used before.	1	2	3	4	5

SOCRATES Scoring Form - 19-Item Versions 8.0

Transfer the client's answers from questionnaire (see note below):

	Recognition	Ambivalence	Taking Steps
	1 _____	2 _____	
	3 _____		4 _____
			5 _____
		6 _____	
	7 _____		8 _____
			9 _____
	10 _____	11 _____	
	12 _____		13 _____
			14 _____
	15 _____	16 _____	
	17 _____		18 _____
			19 _____
TOTALS	Re _____	Am _____	Ts _____
Possible Range:	7-35	4-20	8-40

Mental Health Screening Form–III (MHSF–III)

Instructions: In this program, we help people with *all* their problems, not just their addictions. This commitment includes helping people with emotional problems. Our staff is ready to help you to deal with any emotional problems you may have, but we can do this only if we are aware of the problems. Any information you provide to us on this form will be kept in strict confidence. It will not be released to any outside person or agency *without your permission*. If you do not know how to answer these questions, ask the staff member giving you this form for guidance. Please note, each item refers to your *entire life history, not* just your current situation. This is why each question begins, "Have you ever . . . "

Please circle "yes" or "no" for each question.

1. Have you *ever* talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem? Yes No

2. Have you *ever* felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems? Yes No

3. Have you *ever* been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem? Yes No

4. Have you *ever* been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons? Yes No

5. Have you *ever* heard voices no one else could hear or seen objects or things which others could not see? Yes No

6. (a) Have you *ever* been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself? Yes No
   (b) Did you *ever* attempt to kill yourself? Yes No

7. Have you *ever* had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed? Yes No

8. Have you *ever* experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help? Yes No

9. Have you *ever* given in to an aggressive urge or impulse, on more than one occasion, that resulted in serious harm to others or led to the destruction of property? Yes No

10. Have you *ever* felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior? Yes No

11. Have you *ever* experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner? Yes No

12. Was there *ever* a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up? Yes No

13. Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly nonstop, when you moved quickly from one activity to another, when you needed little sleep, and when you believed you could do almost anything? Yes No

14. Have you ever had spells or attacks when you suddenly felt anxious, frightened, or uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, or you felt dizzy or unsteady, as if you would faint? Yes No

15. Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate. Yes No

16. Have you ever lost considerable sums of money through gambling or had problems at work, in school, or with your family and friends as a result of your gambling? Yes No

17. Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem? Yes No

Print client's name:

Program to which client will be assigned:

Name of admissions counselor: Date:

Reviewer's comments:

The CAGE Questionnaire Adapted to Include Drugs (CAGE-AID)

1. Have you felt you ought to cut down on your drinking or drug use?

2. Have people annoyed you by criticizing your drinking or drug use?

3. Have you felt bad or guilty about your drinking or drug use?

4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

Score: __ /4

2/4 or greater = positive CAGE, further evaluation is indicated

Source: Reprinted with permission from the *Wisconsin Medical Journal.* Brown, R.L., and
Rounds, L.A. Conjoint screening questionnaires for alcohol and drug abuse. *Wisconsin*
Medical Journal 94:135-140, 1995.

Intake History

SECTION 1: Do you have or have you ever had any of the following? If yes, explain:

YES NO

__ __ Arthritis_____
__ __ Asthma
__ __ Back/Neck problem
__ __ Blood clots/Blood Disorders
__ __ Brain injury
__ __ Cancer
If yes: Type_____
__ __ Cardiac Disease
__ __ Cerebral Vascular Accident
__ __ Chronic Headaches
__ __ Diabetes
__ __ Dizziness
__ __ Emphysema
__ __ Epilepsy
__ __ Head Injury
__ __ Hepatitis
__ __ High/low blood pressure
__ __ HIV/AIDS
__ __ Liver Disease
__ __ Mental health disorder
If yes; Hospitalized?_____ Diagnosis_____
__ __ Numbness of Extremities
__ __ Ruptured intervertebral disc
__ __ Seizure disorder
__ __ **Hospitalizations in the last 3 years?** Explain date/diagnosis

_____

_____

_____

CURRENT MEDICATIONS including dose AND prescriber (use additional paper if needed)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Fort Lyon Residential Support Community - Medical Approval Form

The Fort Lyon Supportive Residential Community provides recovery-oriented transitional housing to homeless individuals with substance use disorders. The program combines housing with peer counseling, educational, vocational, and employment services for homeless and formerly homeless persons from across the state of Colorado. Residents enter and participate in the program voluntarily and can remain in the program for up to 24 months.

The following is a list of program entrance requirements for participants' medical approval to enter the program:

- Participants must have a documented substance use disorder and express a strong motivation and desire to change

- Participants must be detoxed from their drug of choice prior to program entry (meeting the ASAM Level 1 Detox Criteria) 72 Hours

- Participants who have chronic medical or behavioral health conditions must be medically approved to enter the program and be sent to the program with a 60 day supply of any required medications.

The Fort Lyon Residential Support Community is located in Las Animas, Colorado a rural community in Bent County. Medical and Behavioral Health services are available within the local community but specialty care is limited and typically located 40 to 90 minutes away from the Fort Lyon Residential Support Community.

Medical approval to enter the program should focus on these barriers to accessing specialty care, which can take weeks to months to access in some cases. Thus the general guidance of not interrupting acute illness, acute or intensive specialty care, planned surgeries, recovery from a recent illness requiring rehab or due to significant limitations in Activities of Daily Living (ADLs) and planned evaluations for time sensitive critical diagnosis treatments should be completed prior to entry into the program.

Chronic Pain management is limited and not likely to be accessible while at the FL program.

A plan for detox, if needed, prior to transportation to the program should be a part of the medical clearance.

All patients should arrive at the program with access to a minimum of 60 days supply of all medications to assist them in their treatment adherence during the time it will take to establish medical or behavioral health care at one of the local medical or behavioral health clinics.

Should insurance or patient safety issues preclude giving the supply to the patient prior to departure, a local pharmacy is available in Las Animas which works closely with the FL program staff.

Val U Med Health Mart 159 Bent Ave Las Animas CO 81054 P 719-456-1691 F 719-456-1425

Physical Exam

Applicants must have a comprehensive physical completed by a provider. A print out from the provider can be sent once it has been completed or it can be sent over with the referral.

This must include a list of any current medications that clients are prescribed and current physical and mental diagnoses and treatment plans.

Please note that a physical and medication list must be received to complete the referral. Incomplete referrals may not remain on the wait list.

Referral Source Signature: _____ Date: _____

Applicant Signature: _____ Date: _____

Medical Approval Information

Patient Name: _____ **DOB:** _____ **Date of Clearance evaluation:** _____

Allergies:

Please fill out or attach current treatment information

Current Medical/Psychiatric Problem List:

Treatment Plan:

Current Medication List:

Directions:

Date of most recent Tuberculosis screening test and results (ideally done within 30 days of program entry): _____

☐ **Patient currently medically approved to enter the Fort Lyon Residential Support Program**

_____ _____ _____

Print Name & Medical Credential Signature Date

Address: _____

Medical Information/Records Ph: _____ and Fax #: _____

In addition to this Medical Clearance Form please fax a copy of your most recent tuberculosis (TB) test results to 719-456-0109. **For more information, please call (719) 662-1100, or visit our website, https://www.coloradocoalition.org/property/fort-lyon-supportive-residential-community**

Medical resource and treatment information for Fort Lyon

Fort Lyon is located in Bent County in SE Colorado, it is a rural area and medical resources are limited. There are some specialists available within 40 miles of Fort Lyon, but a majority are in Pueblo or Colorado Springs, which is over 100 miles away, and may only see patients 1-2 days a week or month. Transportation is limited if you need to see a specialist.

This is to inform you that if you have a need to see a specialist, the services may not be available to you, please consider this prior to submitting your application.

- If you have any pending surgeries complete them PRIOR to entering program.
- If you plan to enter into treatment for Hepatitis C, Cancer, or other long-term treatment with a specialist you need to complete your treatment PRIOR to coming to Fort Lyon.
- Primary care and behavioral health providers are available in the area such as Fort Lyon Health Center, Valley Wide Health Systems, Ryon medical and South East mental Health Group.

Assistance for your initial visit will be provided when you enter the program. Dental and Vision appointments are also available after you have been in the program for 90 Days.

I have read and acknowledge the information above.

Print Client's Name

Client's Signature and Date

_____ _____

Print Case Manager's Name

Referral Source's Signature

_____ _____

Resident Selection Criteria

The Fort Lyon Supportive Residential Community provides recovery oriented transitional housing to homeless individuals with substance use disorders. The program combines housing with counseling, educational, vocational and employment services for homeless and formerly homeless persons from across the state of Colorado, with an emphasis on serving homeless veterans. Residents enter and participate in the program voluntarily and can remain in the program for up to 24 months. The following is a list of program entrance requirements participants must meet in order to eligible. Please keep in mind that each application is reviewed on an individual basis for clinical appropriateness.

1. Participants must be homeless or be at imminent risk of homelessness (see definition on page two)
2. Participants must be at least 21 years or older. Typically persons over the age of 25 are most successful in this environment
3. Participants must have a documented substance use disorder with previous failed attempts at treatment and express a strong motivation and desire to change
4. Participants must be detoxed from their drug of choice prior to program entry - meeting the ASAM Level I Detox Criteria
5. Participants who have a mental health diagnosis must have stable symptoms and have a 30 day supply of all prescription medications at time of transportation
6. Participants who have chronic health conditions must be medically cleared enter the program and be sent to the program with a 30 day supply of any required medication
7. Participants must be a resident of Colorado
8. Ft Lyon does not provide any court ordered treatment, and will not provide any written updates to probation or parole. A background check will be requested prior to the admission/transportation date. Rescission of the admission date will be sent to the referral source if there are open warrants or open cases, if the participant is a registered sex offender or if there is a concerning past history of sexual offenses or recent violent offenses
9. Participants must agree to live in a communal living environment and comply with the Resident Handbook and Fort Lyon Policies and Procedures
10. Participants may bring only one bag of personal belongings to the program

There are no minimum or maximum income requirements for the program and the program is provided free of charge to participants. Please keep in mind that this program generally operates off a waiting list. Referred participants should have an established relationship with the referring organization. Referring organization should be able to contact the participant on an ongoing basis and be able to assist in locating participant when their name comes up on the waiting list. It is suggested that while participants wait to be admitted to the program, that the referring agency work to connect the participants to mainstream benefit including Medicaid and SSI/SSDI, provide the participants assistance in obtaining identification documents and aid in the application process for affordable housing for after program exit. This program is not intended to be an alternative to incarceration and will not accept participants under court ordered treatment. Upon program completion, participants will be assisted in reintegrating into a community of their choice and be provided with resources for ongoing care, housing options and community supports.

Homeless Definition:

a) an individual who lacks a fixed, regular, and adequate nighttime residence;
b) an individual with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;
c) an individual living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including hotels and motels paid for by federal, State, or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing);
d) an individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution;
e) an individual who resided in a shelter or place not meant for human habitation and who is exiting an institution where he or she temporarily resided;
f) an individual who will imminently lose his or her housing, including housing he or she owns, rents, or lives in without paying rent, is sharing with others, and rooms in hotels or motels not paid for by federal, state, or local government programs for low-income individuals or by charitable organizations, as evidenced by: a court order resulting from an eviction action that notifies the individual that they must leave within 14 days;
g) the individual having a primary night time residence that is a room in a hotel or motel and where they lack the resources necessary to reside there for more than 14 days;
h) credible evidence indicating that the owner or renter of the housing will not allow the individual to stay for more than 14 days, and any oral statement from an individual seeking homeless assistance that is found to be credible shall be considered credible evidence for purposes of this clause; and
i) has no subsequent residence identified, or lacks the resources or support networks needed to obtain other permanent housing.
j) or an individual who currently is residing in permanent supportive housing and is at risk of becoming homeless
k) The term "Homeless" does not include any individual imprisoned or otherwise detained pursuant to an act of Congress or a state law.

Application Signature: _____ Date: _____

Referral Organization: _____

Staff Signature: _____ Date: _____

Fort Lyon benefits program eligibility notice

As a participant in the program at Fort Lyon, there are benefits that you are and are not eligible for. Please note any/all programs that affect you and initial each line:

____ SSDI/SSI payments are not affected and residents receive full benefits.

____ VA disability payments are not affected and residents receive full benefits.

____ Medicaid and Medicare are not affected.

____ OAP payments are subject to state exemption criteria and may be reduced to $79/month.

____ AND payments are subject to state exemption criteria and may be reduced to $79/month.

____ Food assistance program (SNAP) is not available for residents of Fort Lyon living in the dorms. Resident may apply once he/she is living in a transitional housing unit. Special diets are not considered as a part of DHS eligibility for food assistance.

I have read this notice and acknowledge the information regarding benefits.

_____ _____

Name Date

*State benefits will remain in the county where you are currently receiving them. You will need to do a change of **mailing address,** with DHS, leaving your residential address in the county they are currently in.

Social Security (retirement/SSI/SSDI) requires address change to new address.
Mailing address will be: (Name) 30999 County Road 15, Las Animas, CO 81054

We will help make that change when you arrive.

OneHome

OneHome Release of Information (ROI)
Authorization to Disclose Protected Health Information

Section 1: Who Is the Individual?

Participant Last Name:	Participant First Name:	DOB (MM/DD/YYYY):
	Social Security Number:	VI-SPDAT Type (Circle One): VI-SPDAT TAY-VI-SPDAT F-VI-SPDAT

I hereby authorize the use or disclosure of protected health information and relevant housing program eligibility information about the Individual named above.

I am: ◯ the Individual named above (complete section 7 below to sign this form)

◯ A personal representative because the patient is a minor, incapacitated or deceased (complete section 8 below)

Section 2: Who Will Be Receiving and Disclosing Information About the Individual?

The following person(s) or entities may use or disclose this information:

All defined partners within the Metro Denver Homeless Initiative Continuum of Care who utilize the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) pre-screen assessment as part of the OneHome Coordinated Entry System. An updated list of these providers is listed on www.onehomeco.org/partners

Section 3: What Information About the Individual Will Be Disclosed?

The information to be disclosed to further housing eligibility and navigation may include:

-Birth Date -Gender -Scanned copies of vital documents
-Contact Information -Income -HIV/AIDS status (only for targeted programs)
-Additional information used for matching towards suitable housing and/or services
Histories of: -Behavioral Health Treatment
-Medical Treatment
-Housing and Homelessness

The information to be disclosed, including behavioral health and/or substance abuse services includes the following:

All information contained within the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) pre-screen assessments for individuals, families and unaccompanied youth, including:

A. History of Housing and Homelessness
B. Risks
C. Socialization and Daily Functioning
D. Wellness
E. Family Unit

Section 4: What is the Purpose of the Information Sharing Disclosure?

To improve access and service alignment by assessing various health and social needs, and then to match those assessed with the most appropriate housing interventions available. The VI-SPDAT is a tool to help guide those assessed to the appropriate services, assist them with the case planning process and track changes over time. The OneHome system database operates over the internet and uses many security protections to ensure confidentiality. The information collected may either be kept in separate databases or in a centralized database connected with HMIS; the information can be updated and may remain in the database or databases past the expiration of this consent or after consent is withdrawn.