Transitional Living Center

Iroquois Center for Human Development, InC
Phone: **620-723-2272** Fax: **620-723-3450**
Email: **housing@irqcenter.com**

Application information

Thank you for your interest in our Transitional Living Program. To ensure a smooth application process please review the following and ensure all information is included (if available). We must receive these documents to move onto the next step of the screening process. Incomplete application packets will be placed on hold until all information is received.

Required Information	Included	N/A
Completed Application	☐	☐
Copies of Insurance Cards	☐	☐
Recent Screens	☐	☐
Releases of Information for any CHMC's	☐	☐
Current Diagnosis/SPMI Determination	☐	☐
Medication List	☐	☐
Recent Therapy Notes	☐	☐
Recent Case Management Notes	☐	☐
Recent Psychosocial Notes	☐	☐
Information from Hospital on Current Status (if applicable)	☐	☐
Program Expectations	☐	☐

Referral Source:

Person Making Referral: ____

Phone Number: ___________________________Email: ____

Relationship to Person Referred: ____

Community Mental Health Center: ____

CMHC Case Manager or Contact Person: ____

Phone Number: ___________________________Email: ____

Transitional Living Center

Program Expectations

Applicant Expectations

Before completing this application, we want to ensure you understand our program and what we would expect from a person moving into the Transitional Living Center. The Transitional Housing Program is voluntary, and consumers are expected to follow the rules to remain in the program.

The goal of the TLC Program is to create healthy habits that can be carried over into independent living. We focus on medication management, cooking, cleaning, managing activities of daily living (bathing, personal hygiene, maintaining personal space, etc.), positive social interactions, symptom management and healthy nighttime routines.

Each house can house up to 4 individuals, each with their own bedroom. The house is always staffed, and staff are there to provide support and teach skills.

A typical length of stay is 3-12 months. This can vary because our program is individualized to each person to meet them at their skill level.

The following is not a complete list of rules or expectations, but a general overview.

Consumers are required to:

- ☐ Attend groups at the Iroquois Center Monday-Friday 9:30am-3pm.
- ☐ Participate in group activities in the Transitional Living Homes.
- ☐ Stay medication compliant.
- ☐ Participate in meal planning, preparation, and housekeeping.
- ☐ Complete ADLs (personal hygiene, clean living spaces, etc.).
- ☐ Work with their Case Manager on short and long-term goals.
- ☐ Attend all scheduled therapy and peer support sessions.
- ☐ Respect housemates and staff.
- ☐ Abstain from caffeine and soda after 6pm.
- ☐ Not use illicit drugs or alcohol (zero tolerance).

After completion of the Transitional Program, our Teams work together to assess the consumers progress and determine if they are ready for independent living. Case Managers will help with the housing process. Consumers may continue to attend groups and receive services from Iroquois after they moved out.

Signature of Applicant	Date

Transitional Living Center
Application For Housing

Personal Information:

Name: ____

SSN: ____________________________ Age: _______ Date of Birth: ________________

Gender: ___________________ Preferred Pronouns: _______________

Current Address: ____

Current Phone Number: _______________________

County of Residence: _________________County of Responsibility: ___________________

Financial Information:

List the monthly amounts for the following income sources.

SSI $_______ SSDI $________ Other $_________

VA benefits $__________ Medicaid Spend Down $___________

Insurance Information

Please send copies of insurance card(s) with this application:

☐ Medicare ☐ Medicaid ☐ Medikan ☐ Private (please list) _______________________

Please list name, phone number, and address for the following if applicable

Do you have a guardian?____

Do you have a payee?____

Do you have a conservator? ____

<u>Family/Contact Information:</u> **Release Signed**

List family member you want contacted in case of an emergency: ____ **Relationship:** ________________________ **Phone:** ____________________ **Address:** ____	**Yes ☐ No☐** ______________ **Date**
Non-family member you want contacted in case of an emergency: ____ **Relationship:** ________________________ **Phone:** ____________________ **Address:** ____	**Yes ☐ No☐** ______________ **Date**
List any family member that you do not want contacted in case of an emergency: ____ **Relationship:** ________________________ **Phone:** ____________________ **Address:** ____	**Yes ☐ No☐** ______________ **Date**

<u>Medical Information:</u> **Release Signed**

Medical Doctor: ____ **Phone:** ____ **Address:** ____	**Yes ☐ No☐** ______________ **Date**
Psychiatrist: ____ **Phone:** ____ **Address:** ____	**Yes ☐ No☐** ______________ **Date**

List other doctors seen within the past year (dentist, optometrist, etc) **Release Signed**

Doctor: ____ **Phone:** ____ **Address:** ____	**Yes ☐ No☐** ______________ **Date**
Doctor: ____ **Phone:** ____ **Address:** ____	**Yes ☐ No☐** ______________ **Date**

Please list mental health diagnosis and all medications you currently take:

Diagnosis

Medication	Dosage	Frequency

Pharmacy: ____ **Phone:** ____ **Address:** ____	**Yes ☐ No☐** ______________ **Date**

List any allergies or medical conditions we should be aware of:

____

____

List all medical and psychiatric hospitalizations within the past year:	**Release Signed**
Hospital: ____ **Reason for Admission:** ________________________________ **Length of Stay:** ______________________________________	**Yes ☐ No☐** ______________ **Date**
Hospital: ____ **Reason for Admission:** ________________________________ **Length of Stay:** ______________________________________	**Yes ☐ No☐** ______________ **Date**
Hospital: ____ **Reason for Admission:** ________________________________ **Length of Stay:** ______________________________________	**Yes ☐ No☐** ______________ **Date**

(List additional hospitalizations on backside of form)

<u>Other Information:</u>

When and where did you last live independently in the community and for how long?

____

Please send a copy of your driver's license with the application.

Do you own a car? ☐ Yes ☐ No Make/Model _______________Color___________

Plate #___________State__________ Driver's License#___________ & State__________

What skills do you wish to learn and what goals do you hope to accomplish by living at the Kelley/Julius House?

____
____
____
____
____

If circumstances occurred and you would need to leave prior to successful completion of the Transitional Living Program, what would be your plan?

____

Where would you live? ____

Who would we contact? ____

Phone #____

What assistance would be helpful for you?

____

****If Psychiatrist questions prescriptions that interfere with driving conditions, they may request that your car keys be turned into staff for your protection.**

****You may be asked to sign a release of information form so that the Iroquois Center for Human Development, Inc., may contact any of the individuals listed on this form.**

****After this form is completed and the requested records are received, the referral will be processed, and an interview will be arranged with the Housing Coordinator. If you are eligible to live at the Kelley/Julius House and there is an opening, the Housing Coordinator will help you with further plans for admission. If you are eligible and there is not an opening, your name will be put on a wait list.**

The information provided in this application is complete and accurate to the best of my knowledge. I understand the process for admission after I submit this application form.

______________________________	______________________
(Person referred)	**(Date of Application)**
______________________________	______________________
(Witness)	**(Date)**

7-03-23 csc