Important! Before you submit this packet!

This application packet cannot be processed until all items on the check list below are completed and included in the packet before submission. If any of the items below are missing, this will hold up your application from being processed. By submitting a completed application packet, we will be able to process your application more quickly!

- ☐ **Completed Application**
- ☐ **Birth/Baptismal Certificate**
- ☐ **Social Security Card (copy only)**
- ☐ **Recent medical records (if applicable)**
- ☐ **Clients Medicaid Card (copy only)**
- ☐ **Signed releases of information (copy only)**
- ☐ **Proof of income (Award Letter from SSI)**
- ☐ **State I.D. or Driver's License**
- ☐ **Full Psychiatric Evaluation :**

Completed within the Last Six Months. This should include DSM-5 diagnosis and ICD-10-CM Codes! Additionally, neuropsychological and psychological evaluation are very helpful and should be included if the consumer has recently had one of these evaluations, however a Full Psychiatric Evaluation completed within the last six months must be included in order for us to process this application packet!

FAIR AND EQUAL OPPORTUNITY HOUSING

POLICY:

Therapeutic Living Services, Inc (TLS) will not discriminate in housing placement on the basis of race, creed, national origin, political affiliation, religion, gender, sexual orientation, or handicapping conditions. Housing placement includes, but is not limited to: application, processing, leasing, transfers, delivery or management services, access to common facilities and termination of occupancy.

PROCEDURE:

1. Every application will receive the policy statement in the application packet.
2. TLS will provide any applicant or resident who believes his/her rights have been violated under the Fair Housing and Equal Opportunity Laws with Form HUD-903, "Housing Discrimination Complaint." The Department of Housing and Urban Development developed this form specifically for reporting agencies which are suspected of discriminating in housing practices. The form should be completed and mailed to:

Dept. of Housing and Urban Development		Therapeutic Living Services, Inc.
Attn: Fair Housing and Equal Opportunity		Attn: Executive Director
PO Box 2905		5601 Domingo Road N.E.
Fort Worth, TX 76113		Albuquerque, NM 87108

3. The Executive Director will meet with the Intake Coordinator and Client Care Committee of the Board of Directors to investigate the complaint and take any corrective actions necessary.

Therapeutic Living Services, Inc.
A Community Mental Health Center
5601 Domingo Rd NE, Albuquerque, NM 87108 Phone: 505-268-5295 Fax: 505-268-9967

NOTICE TO APPLICANTS
RELEASES OF INFORMATION

The authorization forms included in this application allow TLS to receive and share information about you and your application with other agencies and professionals who have provided services to you in the past, as well as interested family members and others that you may wish us to contact. We ask for this information in order to make the best decisions about which of our services are right for you, and so that we may coordinate the care we give you with others as long as you remain a part of TLS.

You are not required to give us your consent to communicate with people you don't want us to contact, although in some cases this could delay or disqualify your application. Even if you do allow us to communicate with someone, you always have the right to revoke that permission. The authorizations you give us automatically expire in one year and we must renew them after that.

TLS or the person who helps you fill out this application may designate specific agencies or individuals that would be helpful to contact. This can be done whenever it is necessary. For your own protection, please DO NOT SIGN any authorization form until it has been completely filled out, especially if the space for the name of the agency or individual is left blank. To protect your confidentiality, TLS will automatically invalidate and destroy any incomplete authorization forms.

APPLICATION FOR SERVICES

Please read all sections and fill out carefully. Incomplete applications will not be considered for services until all necessary information is completed and on file.

Mail or fax your completed application to TLS, Attn: Intake Coordinator.

Date of Referral: ________________ **Applicant's Name:**____

Name of Referring Person: ____

Agency: ____

Applicant Contact information:

Address: ____

Phone: (   )____

* **May messages be left at this number? Yes or No**

Fax: (   )____

Consumer's Date of Birth: _________________________ **SSN:** ___________________________________

Type of Insurance *(circle)* **Medicaid** *(circle type)* Molina Presbyterian Lovelace Value Options
Private Medicare None Other *(specify)* _______________________

Benefits Currently Received *(circle all that apply)* Medicaid Medicare AFDC SSI SSDI VA
Unemployment Food Stamps General Assistance Workman's Comp Pensions
Retirement Accounts Alimony Child Support Section 8 Housing DD
Waiver **Monthly Income and Source:** __________

Services Requested:*

- ☐ Case Management
- ☐ Psychosocial Rehab
- ☐ Therapeutic Group Home
- ☐ Rental Assistance/Independent Living

Race *(circle)* American Indian/Alaskan Native Asian White Black/African American
Native Hawaiian/Other Pacific Islander

Ethnicity (circle) Hispanic Non-Hispanic

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Gender _____ Height _______ Weight _________ Hair ________ Eyes ________ Marital Status _______

Are You: A Veteran? _______ A U.S. Citizen? __________ Currently in a Domestic Violence Situation? ____

Emergency Contact Name ____________________________________ Phone ___________________

Address ____

Legal/Treatment Guardian Name _______________________________ Phone ___________________

Address ____

Medical/Physical Conditions or Developmental Disabilities _______________________________________

Food/Drug Allergies ____

Approximate Household Income per Year * ____________________________________

HELP SPEED UP YOUR APPLICATION

I agree to allow TLS to contact the individuals named below to discuss my application for services.

____ ___________

Signature Date

Name	Address	Phone/Fax
CURRENT PSYCHIATRIST		
CURRENT COUNSELOR/THERAPIST		
CURRENT CASE MANAGER		
FAMILY MEMBER(s) *(SPECIFY RELATION)*		
CURRENT PRIMARY CARE DOCTOR		
PROBATION/PAROLE OFFICER *(IF APPLICABLE)*		

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Please list any counseling/mental health agencies you have received treatment from in the last five years, including inpatient hospitalizations and outpatient psychiatry, counseling, PSR and case management. *(Use additional paper if necessary.)*

Agency Name	Location	Services Received	Dates

Please list your current medications and dosages (Please include any over the counter drugs or herbs you may take)

Medication/Strength	Dosage (How Much, How Often)	Prescribing Doctor

Consumer's Diagnoses:

Mental: ______________________________

____

Medical: ______________________________

____

____

Therapeutic Living Services, Inc.
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Please list any inpatient treatment facilities you have ever been in for alcohol or drug abuse.

Facility Name	Location	Substances Treated	Dates

Have you used any of the following in the past year? *(circle all that apply)*

Alcohol Amphetamines Cocaine/Crack Hallucinogens Opiates (Heroin, Morphine, etc.)

Barbiturates (Seconal, Nembutal, etc.) Non-Prescribed Benzodiazepines (Valium, Xanax, etc.)

Cannabis Inhalants Abuse of Prescription Drugs

If you have used any of the above in the past 30 days, please list ________________

Are you currently using any other non-prescribed drugs? Yes No

If yes, please list ________________

Have you ever been convicted of a felony or other crime? Yes No If yes, please list below.

Date ________ Conviction ________________ Location ________________

Date ________ Conviction ________________ Location________________

Date ________ Conviction ________________ Location________________

Are you currently awaiting trial or sentencing? Yes No If yes, list details ________________

____

Are you currently on parole/probation? Yes No If yes, provide officer's name, address & phone below.

____

____

Therapeutic Living Services
A community Mental Health Center

Authorization to Request/Release Information

Client Name______________________ Date of Birth__________ Social Security#_____________
I herby authorize: Name_____________________________________
Address:____
Phone:______________________________ Fax:
_______________________________________ To: (send to) __x__ Therapeutic Living Services, Inc. the information designated below:

( ) Psychosocial History | (x) Summary Reports | (x) Progress Reports
(x) Psychological Testing Results | (x) Intelligence Testing Results | (x) Psychiatric History
( ) Behavior Problems | ( ) Vocational Testing Results | (x) Psychiatric Evaluations
(x) Service Plans | (x) Medical reports | (x) Psychological Reports
(x) Case Notes | ( ) Personality Profiles | ( ) Entire Record
( ) Other (specify)____

Receive from: __x__ Therapeutic Living Services, Inc. the information designated below:

( ) Psychosocial History | ( ) Summary Reports | ( ) Progress Reports
( ) Psychological Testing Results | ( ) Intelligence Testing Results | ( ) Psychiatric History
( ) Behavior Programs | ( ) Vocational Testing Results | ( ) Psychiatric Evaluations
( ) Service Plans | ( ) Medical Reports | ( ) Psychological Reports
( ) Case Notes | ( ) Personality Profiles | ( ) Entire Record
( ) Other (specify)
____

I authorize that the information exchanged may include records relating to (initialing authorizes those checked):

(x) Psychiatric Conditions Initial________
(x) Substance Use Information Initial_______
(x) AIDS/HIV Testing initial_______

The above information will be used for the following purposes:

(x) Planning Appropriate Treatment or Program | ( ) Case Review
( ) Continuing Appropriate Treatment or Program | ( ) Updating Files
(x) Determining Eligibility for Benefits or Program | ( ) Other
(specify)____

I authorize that information shared may be communicated via telephone, fax, or e-mail as needed.Initial___
I understand that authorizing the disclosure of this health information is voluntary and I can refuse to sign this authorization. I understand that I may revoke this consent at any time by providing written notice, however if I do revoke my signed consent, it may affect my eligibility for services at TLS. I understand that after one year this consent expires. I have been informed what will be given, it's purpose and who will receive the information.

Signature of Client ____________________________________ Date ___________
Signature of Witness ___________________________________ Date ___________
Signature of Representative/Guardian ________________________ Date____________
If client is unable to sign, state reason: ____

This information is disclosed from records whose confidentiality is protected. The receiving agency is prohibited from making any further disclosure of it without the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information is not sufficient for this purpose. The information is protected both by State (section 34-2A18 NMSA 1953) and Federal (42 CFR Part 2) Regulations.

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Therapeutic Living Services
A community Mental Health Center

Authorization to Request/Release Information

Client Name______________________ Date of Birth__________ Social Security#_____________
I herby authorize: Name_____________________________________
Address:____
Phone:_______________________________ Fax:
_______________________________________ To: (send to) __x__ Therapeutic Living Services,
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(x) Psychological Testing Results	(x) Intelligence Testing Results	(x) Psychiatric History
( ) Behavior Problems	( ) Vocational Testing Results	(x) Psychiatric Evaluations
(x) Service Plans	(x) Medical reports	(x) Psychological Reports
(x) Case Notes	( ) Personality Profiles	( ) Entire Record

( ) Other (specify)____

Receive from: __x__ Therapeutic Living Services, Inc. the information designated below:

( ) Psychosocial History	( ) Summary Reports	( ) Progress Reports
( ) Psychological Testing Results	( ) Intelligence Testing Results	( ) Psychiatric History
( ) Behavior Programs	( ) Vocational Testing Results	( ) Psychiatric Evaluations
( ) Service Plans	( ) Medical Reports	( ) Psychological Reports
( ) Case Notes	( ) Personality Profiles	( ) Entire Record

( ) Other (specify)
____
I authorize that the information exchanged may include records relating to (initialing authorizes those checked):

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(x) Substance Use Information Initial_______
(x) AIDS/HIV Testing initial_______

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( ) Continuing Appropriate Treatment or Program ( ) Updating Files
(x) Determining Eligibility for Benefits or Program ( ) Other
(specify)____

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Signature of Representative/Guardian _______________________ Date____________
If client is unable to sign, state reason: ______________________________________

This information is disclosed from records whose confidentiality is protected. The receiving agency is prohibited from making any further disclosure of it without the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information is not sufficient for this purpose. The information is protected both by State (section 34-2A18 NMSA 1953) and Federal (42 CFR Part 2) Regulations.

Common Application for All Continuum of Care Projects

Version 2-8-18

This application is for HUD Continuum of Care (CoC) funded housing programs in Albuquerque. HUD CoC housing programs are for individuals and families that are currently experiencing homelessness. There are many HUD CoC programs in Albuquerque. They all use this application to determine whether an applicant is eligible for their specific CoC program.

Head of Household Information

Date application was completed:

Applicant Name:

Preferred Name (if any):

What gender do you identify with?

☐ Woman ☐ Man ☐ Trans Woman ☐ Trans ☐ Gender Non Conforming

☐ Not Listed - Please Write In: ____

Applicant Date of Birth:

Applicant Phone Number:

Is it safe to leave a message? ☐ ☐ No

Applicant Email Address (if available):

Applicant Mailing address (if available):

If we have trouble contacting you, is there anyone else we can contact (i.e. friend, family member or case manager)

Name of Contact	Phone Number	Email Address

Additional Household Members

Please list all other household members who would be living in the housing unit with you. Include household members who are currently *not* staying with you but who *will live with you once you having housing.*

Name	Relationship	Age

Homelessness History *Documentation of current living situation is required before applicant can be accepted into a CoC Housing Program. For some CoC Housing Programs, documentation of prior months/episodes of homelessness will also be required.*		
What is your current living situation (check one):		
	Housed, but about to be evicted	How much longer can you stay there?
	Emergency Shelter	
	Fleeing domestic violence	
	Doubled up with family/friends	How much longer can you stay there?
	Hospital/Nursing Home	How long have you been there?
	Jail or Prison	How long have you been there?
	Motel/Hotel paid for by you	
	Motel/Hotel paid for by an agency	
	Place not meant for human habitation	
	Substance abuse recovery program	How long have you been there?
	Transitional Housing program	
	Other (Please Describe):	

If you are currently living in a hospital/nursing home, jail/prison, a substance abuse recovery program or transitional housing program, briefly describe where you were living immediately before:

Please provide a brief description of your current living situation:

Have you been continuously living in an emergency shelter or place not mean for human habitation for at least 12 months? ☐ Ye ☐ No

How many separate times have you lived in an emergency shelter or place not mean for human habitation in the last 3 years? ______# of times

If you added up all these times, would it be more or less than 12 months? ☐ More ☐ Less

Disability Information

Documentation of disability is required before an applicant can be accepted into a CoC Permanent Supportive Housing Program.

Does applicant or another household member have a disability that is expected to be of long duration?
☐ ☐ No

If yes, check which type of disability (check all that apply)

	Type of Disability	**Name of household member who has the disability**
	Mental Health	
	Substance Abuse	
	Developmental Disability	
	HIV AIDS	
	Physical Disability or Chronic Illness	

Certification	
I certify that the information provided in this application is true and complete to the best of my knowledge and belief. I understand that all CoC housing programs will need to obtain documentation of my current living situation before determining eligibility. I understand that some types of CoC housing programs will also need to obtain documentation of my past months/episodes of homelessness and documentation of my disability (or household member's disability) before determining eligibility.	
Applicant Printed Name:	
Applicant Signature:	Date:

	Release of Information
	This Common Application may be shared with any New Mexico Continuum of Care funded housing program that may be able to assist me with housing.
	This Common Application may be shared with the NM Coordinated Entry System which may be able to assist me with housing.
	This Common Application may only be shared with the following Continuum of Care funded housing programs (list here):
	This Common Application may **not** be shared with any other program.

Applicant Printed Name:	
Applicant Signature:	Date:

This release of information expires within 1 year of the date it is signed.

For Internal Use Only
Please complete and return this page of the Common Application via fax or email to Coordinated Assessment System staff within 48 hours of making an eligibility decision. Fax: 1-888-527-6480 Email: cap@nmceh.org

Program Information	
Agency:	
Housing Program:	
Name and Title of Person Determing Eligibility:	
Email:	Phone:
Applicant Information	
Applicant HMIS #:	
As of ______________ (date), applicant was ranked as # ______out of #_______ on the CAS prioritization list.	
Eligibility Determination	
____ HUD required eligibility documentation has been secured and applicant is eligible for the above CoC ousing program.	
____ Applicant was determined to be ineligible for the above program for the following reason:	
1. ____ Applicant does not meet HUD requirements for CoC Housing Program. Please explain:	
2. ____ Applicant does not meet program specific eligibility requirements. Please explain:	
3. ____ The applicant is not permitted to participate in services provided by this agency due to a history of dangerous or threatening behavior to agency staff. Please explain:	
4. ____ Applicant was unreachable after _______ attempts were made to contact them within ________ days and is no longer being considered for participation in the above program at this time.	