

**LONG ISLAND SINGLE POINT OF ACCESS (SPA)**  
**PPC, Building 72-2**  
**998 Crooked Hill Road**  
**Brentwood, NY 11717**  
**(631) 231-3562 – phone**  
**(631) 231-4568 – fax**

Thank you for your interest in applying for residential services through the Suffolk County Single Point of Access (SPA). Enclosed please find the revised Long Island Universal Housing Application.

Please be aware that as of June 1, 2002, all applications for Mental Health Adult Housing services will be processed through the new Single Point of Access (SPA). At this time, all waiting lists for Mental Health Adult Housing Services will be transferred to the SPA for processing and the Individual Housing Providers will no longer maintain a separate agency waiting list.

In order to process the application in a timely manner, the following must be included:

- A Psychiatric Evaluation signed by a licensed psychiatrist.
- The application completed in its entirety signed by the applicant.
- A detailed Psycho-Social Summary.
- A Physical exam including a PPD.
- A Physician's Authorization Form signed by a licensed physician (needed for any supervised, intensive supportive or supportive programs)
- Completed Housing Preferences Form.

**All materials mentioned above must be signed and dated within one year of the application date.**

Incomplete referrals will result in the application being placed on hold and may delay potential placement.

In addition, it is recommended that you keep the original copy of the referral and that a copy be submitted to the SPA.

Please mail this referral to:

**LONG ISLAND SINGLE POINT OF ACCESS (SPA)**  
**PPC, Building 72-2**  
**998 Crooked Hill Road**  
**Brentwood, NY 11717**

# Long Island Mental Health Housing Application

**Applicant's Name (Please Print Clearly):** \_\_\_\_\_

**SS#** \_\_\_\_\_

## INSTRUCTIONS

Completed applications **MUST** include:

- Psychosocial History
- Psychiatric Summary (including current clinical assessment signed off by a licensed Psychiatrist)
- Recent Physical Exam (including PPD exam within 1 year of application date signed off by licensed physician)
- Physician's Authorization Form (licensed: Supervised and Apartment Treatment only)
- Completed Housing Preference Form.

**Any omissions will delay potential placement.**

Please indicate the program for which you would like to be considered (Please see summary):  
(Check A, B and / or C)

- \_\_\_\_\_ A. Supervised Community Residence
- \_\_\_\_\_ B. Apartment Treatment A
- \_\_\_\_\_ C. Apartment Treatment B
- \_\_\_\_\_ D. Supported Housing

Please check any specific program you would be appropriate for (see summary for details)

- \_\_\_\_\_ M.I.
- \_\_\_\_\_ M.I. / M.R.
- \_\_\_\_\_ Senior Citizens / Geriatric (Nassau Only-Over 55)
- \_\_\_\_\_ MICA
- \_\_\_\_\_ SOCR
- \_\_\_\_\_ RCCA (RCCA) (Suffolk Only)
- \_\_\_\_\_ Young Adult (Ages 18-25)
- \_\_\_\_\_ Family Housing (Supported Housing Only)
- \_\_\_\_\_ Couples (Supported Housing Only)

Specify other individual: \_\_\_\_\_

*(May require additional application for other individual)*

- \_\_\_\_\_ HUD - Homeless Housing
- \_\_\_\_\_ HIV / AIDS Housing (requires additional consent)
- \_\_\_\_\_ Other \_\_\_\_\_

Agency Preference (if any): \_\_\_\_\_

Geographic Preference (if any): \_\_\_\_\_

- Please check here if the applicant is **not** interested in services of the Peer Specialist Team. In the event the above is not checked, the Housing Preferences Form will be forwarded to the Peer Specialist Team.

I agree with this referral and give my consent for information about myself to be shared with agencies in connection with my referral to a housing program. I also agree that all the information contained herein is accurate to the best of my knowledge and is reflective of my current situation. See consent form.

**Current Contact Info:** (       ) \_\_\_\_\_

Date \_\_\_\_\_

Signature of Applicant (**Required**) \_\_\_\_\_

Signature of Witness \_\_\_\_\_

## Summary

### Program descriptions

The following programs are operated by private, not-for-profit organizations licensed by the New York State Office of Mental Health. The programs are supervised by trained professionals who are available (via beeper or telephone) as needed in addition to regularly scheduled on-site hours. Residents are offered Restorative Services and are trained in the following areas:

*Assertiveness / Self-Advocacy Training; Community Integration / Resource Development; Daily Living Skills; Health Services; Medication Management / Training; Parent Training; Rehabilitative Counseling; Skill Development; Socialization; Substance Abuse Services; Symptom Management*

These programs are considered transitional housing. Individuals applying for Senior Citizen / Geriatric CRs (Nassau Only) must be 55 and over. Individuals applying for placement in MI / MR housing must fall between 65-85 IQ. There are three levels of care under the title Community Residence Program:

### Supervised CR (Licensed):

These programs are supervised 24 hours per day. Overnight staff members are available. These residences typically house 8-12 individuals in one large house. Residents are offered all restorative services (listed above), generally with an emphasis on Daily Living Skills such as cooking, cleaning, personal hygiene, food shopping and money management. Medication is supervised as needed.

### State Operated Community Residence (SOCR)(Licensed):

This level houses between 10-24 residents, staffed 24 hours a day, meals and social activities provided. Services are the same as above.

### Residential Care Center for Adults (RCCA)(Licensed) Suffolk

**Only:** RCCA is a structured environment. This level houses 130 residents, staffed 24 hours a day, meals and social activities are provided. Medication is monitored by staff.

### Apartment Treatment A and B (Licensed):

These programs typically receive staff visits from 5-7 (A) times per week to 1-4 (B) times per week. There are generally 2-3 residents per house or apartment. Residents are expected to have good daily living skills and be able to hold their own medication. Food is not provided. Instead, residents receive an allowance, which is used to purchase food and cleaning supplies.

### Supported Housing:

Supported Housing programs vary. Programs may offer individual bedrooms or triple accommodations in individual placement or with family. Individuals residing in Supported Housing pay 30% of their monthly income toward their rent. The rest of their rent is subsidized. Residents of these programs live fairly independently and may receive visits 1-4 times monthly. Supported Housing is considered long-term housing.

### Homeless Housing:

All homeless programs are subject to the HUD definition of homelessness as there are different regulations for homeless housing.

## Long Island Mental Health Housing Application

**Section A: Identifying Information:** *(Please print clearly)*

1. First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_
2. AKA: \_\_\_\_\_
3. Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (age: \_\_\_\_\_ )
4. Social Security #: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
5. Gender: ( ) Male ( ) Female
6. Current Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Domestic Partner
7. Homeless: ( ) Yes ( ) No If Yes, check type: ( ) Currently ( ) Pending ( ) Other (Please use Page 6 to explain)
8. Address: (if applicant is homeless, indicate location. If applicant is hospitalized, list address / location prior to hospitalization on A side. If applicant currently lives in a Mental Health Facility, list address and info on B side.)
- (A) Street: \_\_\_\_\_ Apt. # \_\_\_\_\_ (B) Agency Name: \_\_\_\_\_
- City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Street: \_\_\_\_\_
- Phone #: ( ) \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
- Phone #: ( ) \_\_\_\_\_
9. Emergency Contact Name: \_\_\_\_\_
- Address: Street: \_\_\_\_\_ Apt #: \_\_\_\_\_
- City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_
- Number of Children to be housed? \_\_\_\_\_ Age(s) and Sex: \_\_\_\_\_
- Special Conditions: \_\_\_\_\_
- \*\*10. Applicant's Ethnicity: \_\_\_\_\_
- Citizenship: ( ) USA ( ) Other
- If other, specify: \_\_\_\_\_
11. Is the applicant a Veteran? ( ) Yes ( ) No
- Type of Discharge: \_\_\_\_\_
12. List all Entitlements and income which the applicant receives or which are pending:

	Monthly Dollar (\$) Amount	ID Number or "P" for Pending
( ) Social Security	_____	_____
( ) SSI	_____	_____
( ) SSD	_____	_____
( ) PA	_____	_____
( ) Veterans	_____	_____
( ) Medicare	_____	_____
( ) Medicaid	_____	_____
( ) Food Stamps	_____	_____
( ) Pension	_____	_____
( ) Wages	_____	_____
( ) Worker's Comp	_____	_____
( ) Unemployment	_____	_____
( ) Other	_____	_____

Does the applicant have a Representative Payee? ( ) Yes ( ) No

If yes: Name: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_

Is the applicant paying an overpayment: ( ) Yes ( ) No

How much? \_\_\_\_\_ To what agency? \_\_\_\_\_

13. Is the applicant currently receiving or eligible for any of the following?

**CSS:**

Contact Person: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ ( ) Yes ( ) No ( ) Pending

**CSS Waiver:**

Contact Person: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ ( ) Yes ( ) No ( ) Pending

**ICM:**

Contact Person: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ ( ) Yes ( ) No ( ) Pending

**AOT:**

Contact Person: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ ( ) Yes ( ) No ( ) Pending

**AOT Service Enhancement (Diversion):**

Contact Person: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ ( ) Yes ( ) No ( ) Pending

**ACT:**

Contact Person: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ ( ) Yes ( ) No ( ) Pending

*\*\*This question is asked for statistical purposes only. Applicants will not be discriminated against based on race, color, creed, religion, sex, national origin, age, familial status, handicap or sexual preference.*

## Long Island Mental Health Housing Application

Applicant Name (Please print clearly): \_\_\_\_\_

SS #: \_\_\_\_\_

Section B: Housing, Employment and Education History & Preferences	Section C: Skills / Supports Assessment																																																																																																																																																				
<p>1. Please list where the applicant has resided for the past five years and detail any history of homelessness. Include shelters, drop-in centers, streets, hospitals, prison, supportive residences, SRO's, family and independent housing (please start with most recent location):</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 20%;">Dates</th> <th style="width: 40%;">Location</th> <th style="width: 40%;">Reason for Leaving</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table> <p>2. Has applicant been employed during the last five years?  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown                      If yes, please list dates and positions:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 20%;">Dates</th> <th style="width: 80%;">Position / Title / Type of Employment</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>	Dates	Location	Reason for Leaving																															Dates	Position / Title / Type of Employment									<p>1. 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<p>3. Educational / Training History (<i>check all relevant items</i>):</p> <p><input type="checkbox"/> Special Education</p> <p><input type="checkbox"/> Some High School</p> <p><input type="checkbox"/> H.S. Diploma or GED</p> <p><input type="checkbox"/> Some College</p> <p><input type="checkbox"/> College Degree</p> <p><input type="checkbox"/> Master's Degree or higher</p> <p><input type="checkbox"/> Vocational Training, Trade: _____</p> <p><input type="checkbox"/> VESID Sponsorship: _____</p> <p>4. What is the reason this referral is being made at this time?                      (Please answer on Page 5).</p>	<p>3. Indicate all support services needed once the applicant is housed:</p> <table style="width: 100%; border-collapse: collapse;"> <tbody> <tr><td>Health</td><td style="text-align: center;">( )</td></tr> <tr><td>Educational Program</td><td style="text-align: center;">( )</td></tr> <tr><td>MICA (Dual Dx) Day Program</td><td style="text-align: center;">( )</td></tr> <tr><td>MIMR</td><td style="text-align: center;">( )</td></tr> <tr><td>Psychiatric Day Program</td><td style="text-align: center;">( )</td></tr> <tr><td>Therapy</td><td style="text-align: center;">( )</td></tr> <tr><td>Clubhouse</td><td style="text-align: center;">( )</td></tr> <tr><td>Psychiatric Clinic / Psychiatrist</td><td style="text-align: center;">( )</td></tr> <tr><td>Alcohol / Drug Treatment Services</td><td style="text-align: center;">( )</td></tr> <tr><td>Alcoholics / Narcotics Anonymous</td><td style="text-align: center;">( )</td></tr> <tr><td>Vocational Program</td><td style="text-align: center;">( )</td></tr> <tr><td>On-site Case Management Services</td><td style="text-align: center;">( )</td></tr> <tr><td>Probation / Parole</td><td style="text-align: center;">( )</td></tr> <tr><td>Cognitive Rehab</td><td style="text-align: center;">( )</td></tr> <tr><td>None</td><td style="text-align: center;">( )</td></tr> <tr><td>Other: _____</td><td style="text-align: center;">( )</td></tr> </tbody> </table>	Health	( )	Educational Program	( )	MICA (Dual Dx) Day Program	( )	MIMR	( )	Psychiatric Day Program	( )	Therapy	( )	Clubhouse	( )	Psychiatric Clinic / Psychiatrist	( )	Alcohol / Drug Treatment Services	( )	Alcoholics / Narcotics Anonymous	( )	Vocational Program	( )	On-site Case Management Services	( )	Probation / Parole	( )	Cognitive Rehab	( )	None	( )	Other: _____	( )																																																																																																																				
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## Long Island Mental Health Housing Application

Applicant Name (Please Print Clearly): \_\_\_\_\_

SS#: \_\_\_\_\_

### Section D: Psychiatric Information

1. Current Diagnosis (*Include ALL Axis I and Axis II diagnoses and Diagnostic and Statistical Manual (DSM-IV Codes)*):

Axis I:		
Axis II:		
Axis III:		
Axis IV:		
Axis V:		

If available, IQ test used: \_\_\_\_\_  
 Score: \_\_\_\_\_ Date: \_\_\_\_\_  
 Psychiatrist's Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: (\_\_\_\_) \_\_\_\_\_

2. Does the applicant have a history of, or is the applicant currently exhibiting any of the following?  
 (*Fill in all items: C = Current, H = History, both C and H if appropriate, N = Neither or U = Unknown.*)

	<b>C</b>	<b>H</b>	<b>N</b>	<b>U</b>
Homicidal Ideas / Attempts	( )	( )	( )	( )
Delusions	( )	( )	( )	( )
Hallucinations	( )	( )	( )	( )
Disruptive Behavior	( )	( )	( )	( )
Severe Depression	( )	( )	( )	( )
Highly Disorganized Thought Processes	( )	( )	( )	( )
Criminal Activities / Arrests	( )	( )	( )	( )
Cognitive Impairment	( )	( )	( )	( )
Aggressive / Assaultiveness	( )	( )	( )	( )
Suicidal Ideas / Attempts	( )	( )	( )	( )
Arson / Firesetting	( )	( )	( )	( )
Sexual Acting Out	( )	( )	( )	( )
Compulsive Behaviors	( )	( )	( )	( )
Inappropriate Touching	( )	( )	( )	( )
Substance / Alcohol Abuse	( )	( )	( )	( )

3. Current Psychotropic Medications:

Name	Dosage	Schedule

4. What level of support does the applicant require to achieve medication compliance?  
 None, Independent  
 Supervision  
 Reminders  
 Refuses / Non-compliant  
 Not Applicable

5. Is the applicant currently hospitalized?  Yes  No  
 If so, date of admission: \_\_\_\_\_  
 Hospital name and ward: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_  
 Phone: (\_\_\_\_) \_\_\_\_\_

6. To the degree known, list all psychiatric hospitalizations and psychiatric emergency room use:

Hospital / ER	Adm. Date	Dis. Date	Reason

Total length of time hospitalized: \_\_\_\_\_

7. Does the applicant have a history of substance abuse?  
 Yes - Substance(s): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Frequency of use:  
 Daily  
 Several times / week  
 Once weekly  
 No  
 Less than once a week  
 Not Applicable  
 Unknown

8. Does the applicant have a history of substance abuse treatment?  
 Yes  No

Name of Treatment Program	Date

Length of time the applicant has spent substance free:  
 Alcohol: since \_\_\_\_ / \_\_\_\_  Not Applicable  
 Drugs: since \_\_\_\_ / \_\_\_\_  Not Applicable

## Long Island Mental Health Housing Application

Applicant Name (Please print clearly): \_\_\_\_\_

SS#: \_\_\_\_\_

<p><b>Section E: Medical Information</b>                  The disclosure of HIV-Related Information is not required, but if the applicant wishes to release it, this form must include a special consent to Release Information Form signed by the applicant.                  This is to be added as Page 7.</p>																																													
<p>1. Medical Diagnosis: <i>(Include ALL Axis III Diagnoses)</i>:                   _____                   _____                   Allergies: _____</p>	<p>Does the applicant have a medical condition that requires special services? ( ) Yes ( ) No</p> <p>If so, indicate which services:</p> <p>( ) Special medical equipment                  Please Specify: _____</p> <p>( ) Medical supplies                  Please Specify: _____</p> <p>( ) Ongoing physician support                  ( ) Nursing services                  ( ) Home Care                  ( ) Therapeutic diet                  ( ) Injectable medication                  ( ) Other _____</p>																																												
<p>2. Current non-psychotropic medications:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;">Name</th> <th style="width: 20%;">Dosage</th> <th style="width: 20%;">Schedule</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>	Name	Dosage	Schedule																<p>What medical services is the applicant currently receiving?</p> <p>_____</p>																										
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<p>3. To the degree known, list all medical hospitalizations during the past <i>three</i> years:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Hospital</th> <th style="width: 15%;">Adm. Date</th> <th style="width: 15%;">Dis. Date</th> <th style="width: 40%;">Chief Complaint</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	Hospital	Adm. Date	Dis. Date	Chief Complaint																	<p>Name, address and telephone number of treating physician:                   _____                   _____</p>																								
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<p>4. Physical Functioning Level <i>(Answer each of the following)</i>:</p> <table style="width: 100%;"> <thead> <tr> <th></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> </tr> </thead> <tbody> <tr><td>Fully Ambulatory</td><td style="text-align: center;">( )</td><td style="text-align: center;">( )</td></tr> <tr><td>Climbs one flight of stairs</td><td style="text-align: center;">( )</td><td style="text-align: center;">( )</td></tr> <tr><td>Bedridden</td><td style="text-align: center;">( )</td><td style="text-align: center;">( )</td></tr> <tr><td>Wheelchair Required</td><td style="text-align: center;">( )</td><td style="text-align: center;">( )</td></tr> <tr><td>Amputee</td><td style="text-align: center;">( )</td><td style="text-align: center;">( )</td></tr> <tr><td>Blind</td><td style="text-align: center;">( )</td><td style="text-align: center;">( )</td></tr> <tr><td>Deaf</td><td style="text-align: center;">( )</td><td style="text-align: center;">( )</td></tr> <tr><td>Mute</td><td style="text-align: center;">( )</td><td style="text-align: center;">( )</td></tr> <tr><td>Incontinent</td><td style="text-align: center;">( )</td><td style="text-align: center;">( )</td></tr> <tr><td>Needs help with toileting</td><td style="text-align: center;">( )</td><td style="text-align: center;">( )</td></tr> <tr><td>Can fully bathe self</td><td style="text-align: center;">( )</td><td style="text-align: center;">( )</td></tr> <tr><td>Can feed self</td><td style="text-align: center;">( )</td><td style="text-align: center;">( )</td></tr> <tr><td>Can dress self</td><td style="text-align: center;">( )</td><td style="text-align: center;">( )</td></tr> </tbody> </table>		Yes	No	Fully Ambulatory	( )	( )	Climbs one flight of stairs	( )	( )	Bedridden	( )	( )	Wheelchair Required	( )	( )	Amputee	( )	( )	Blind	( )	( )	Deaf	( )	( )	Mute	( )	( )	Incontinent	( )	( )	Needs help with toileting	( )	( )	Can fully bathe self	( )	( )	Can feed self	( )	( )	Can dress self	( )	( )	<p>Does applicant have pets? ** ( ) Yes ( ) No                  If yes, please specify: _____</p> <p>** Please be aware that different programs have varying policies regarding pet ownership. In addition, pets may affect your entry into mental health housing.</p> <p>Is the applicant allergic to animals? ( ) Yes ( ) No                  If yes, please specify: _____</p> <p>Does applicant smoke cigarettes? ( ) Yes ( ) No</p> <p>Does applicant have any additional challenges or issues that may impact placement into mental health housing?                   _____                   _____                   _____</p>		
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## HOUSING PREFERENCES FORM

Applicant's Name: \_\_\_\_\_ SS#: \_\_\_\_\_

The applicant should fill out this form, with assistance if necessary. The questions are intended to clarify the applicant's housing preferences and to highlight the areas where a substantial difference between types of housing supports exist. The applicant is to specify his/her preferences today. The applicant, with assistance if necessary, may find it helpful to identify long-term housing goals and the immediate steps that may help to reach these goals. It is assumed that these preferences may change over time.

This information will be shared with the SPA Team to help identify your interests, but it does not provide a guarantee that your preferences will be satisfied.

1. Do you have a particular town or area that you would like to live in?

1<sup>st</sup> Preference \_\_\_\_\_

2<sup>nd</sup> Preference \_\_\_\_\_

2. Please circle Yes or No in response to the following questions.

Would you like assistance with learning how to:

- |   |           |
|---|-----------|
| A. Prepare your own meals?  | YES<br>NO |
| B. Manage your money?   | YES<br>NO |
| C. Take your medication as prescribed?  | YES<br>NO |
| D. Have good personal hygiene skills?   | YES<br>NO |
| E. Travel (use buses, trains, etc.)?  | YES<br>NO |
| F. Keeping your personal area clean?  | YES<br>NO |
| G. Do your own laundry?   | YES<br>NO |
| H. Is there anything else you need help with?<br>(If yes, please be specific) | YES<br>NO |

---

(Please turn over)

3. In addition to your Service Plan, are you interested in:  
A Community Based Alternative Treatment Program: (Clubhouse  
Model Program, Psychosocial Program, School or Vocational  
Training) \_\_\_\_\_

Employment or an Employment Readiness Program \_\_\_\_\_

Participating in the Housing Agency's Consumer Counsel \_\_\_\_\_

Other? Please specify: \_\_\_\_\_

4. Are you interested in participating in social or recreational activities  
sponsored by the housing agency?

YES NO

5. Do you require handicap-accessible housing?

YES NO

If yes, please be specific: \_\_\_\_\_

\_\_\_\_\_

6. What other services are you seeking? (Self-help, AA, NA,  
EA, Double Trouble, Social, etc.) Please be specific: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7. Is there anything else you would like the committee to know? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_