Applying for the Transition House, Inc. Transitional Living Program

Before you begin the application process, please review the following requirements for prospective applicants:

- You must be 18 years old or older.
- You must be diagnosed with a serious mental illness and currently receiving service from a mental health professional in either an inpatient or outpatient setting.
- You must be willing to improve upon one or more of the following skill areas:
    - Daily living and community living skills.
    - Social and recreational skills.
    - Pre-vocational and vocational skills.
    - Self-esteem, communication, and building healthy relationships.
    - Advocacy.
- You are motivated and committed to your mental health recovery.
- You have no recent history of alcohol or other substance abuse.
- You are willing and have the skills to maintain your sobriety.
- You are willing to maintain medication compliance and have the ability to self-administer medication.
- You have no history of violent criminal charges or sex crimes.
- You have had a negative tuberculosis test in the past 6 months or are able to provide documentation from a health professional stating you are able to live in a communal living situation.
- You are willing to live in a congregate/shared living situation with up to two roommates.
- You are able to live in a supportive environment without 24 hour/day supervision.
- You are willing to follow the agreements, policies and procedures of the Transition House, Inc. program.
- Clients of Central Oklahoma Community Mental Health Center and Griffin Memorial Hospital will be given priority in consideration.

Transition House, Inc. reserves the right to refuse to provide services to those who:

- Do not have a diagnosed serious mental illness.
- Present an immediate safety risk to staff, volunteers, and/or clients.
- Have intellectual, psychiatric, and/or physical impairments that would preclude them from fully participating in the program or functioning independently.
- Are married or related to any member of staff or Board of Directors.
- Are married or related to another person in the Transitional Living Program.
- Are solely in need of shelter.

Transition House, Inc. reserves the right to ban individuals from the agency and all of its property who display behaviors that place the agency, Board of Directors, staff, and/or program participants at risk.

Transition House Inc. Transitional Living Program Screening Process

Mental Health Professional Checklist:

- The Transitional Living Program application can be found on our website, www.thouse.org or can be located at Transition House, Inc office located at 700 Asp Ave Suite #2 Norman, OK 73069
- **All four parts of the application must be completed:**
  - ☐ **Mental Health Professional referral for service (Page 3-4):** to be completed by the mental health professional (therapist, case manager, PRSS, etc).
  - ☐ **Consent for Release of Confidential Information:** this should come from the applying agency/facility allowing Transition House to obtain the following:
    a. **Psychosocial and/or psychiatric evaluation.**
    b. **Recent assessment & treatment plan.**
    c. **Recent progress notes.**
    d. **Pertinent medical records.**
    e. **TB test results done within the past 6 months.**
  - ☐ **Client Request for Services (Page 5-6):** to be completed by the client.
  - ☐ **Client Assessment (Page 7-8):** to be completed by the client.
- Once the application is complete it can be faxed to the Programs Director at (405) 360-2339, dropped off, or mailed to the Transition House, Inc. office, or emailed to the Programs Director at asherf@thouse.org.
- If you have questions regarding the application process, please feel free to call the Programs Director at (405) 360-7926.

Interviews:

- If the client is an appropriate fit for the Transitional Living Program, the Programs Director will contact the client and/or mental health professional to schedule an interview.
- Ideally, the interview will be in person at Transition House, Inc., and the prospective client will sit in on a psychoeducational group before the interview. Afterwards, the client will meet with the Programs Director and a Recovery Coordinator to complete the interview. In total between the group and the interview the client should expect to be at Transition House, Inc. for 2 hours.
  - These interviews/groups will be scheduled in the morning between Monday-Wednesday.
- If the client is unable to attend the interview in person, an interview over Zoom can be scheduled as an alternative.

Acceptance/Deferment:

- After the client has completed the interview requirements, the Transition House, Inc. clinical team will meet to discuss whether the client will have placement in the Transitional Living Program.
- The client and/or mental health professional will be notified of the decision by the end of the week.
- If the client is accepted, the Programs Director will set up a day/time for the client's orientation and move in date. (Move ins typically occur Monday or Tuesday mornings).

Mental Health Professional's Referral for Services

(To be completed by the mental health professional)

Client's first, middle, last name (including maiden name):	Date of birth:	Age:	Date of referral:

Client's gender identity:	Highest education level:	Race:	Veteran status:

Mental health professional's name:	Agency:	Phone number:

Diagnosis
(Include diagnostic impressions & current medical conditions)

_____

_____

_____

_____

Current Medications
(Include all mental health & physical health medications)

_____

_____

_____

_____

Mental Health History

Age of onset:	# of psychiatric hospitalizations:	# of suicide attempts:	Hallucinations:

Alcohol/substance abuse: ◯ Yes ◯ No	Age of first use:	Date of last use:	Primary substance of choice:

Does the client have a history of violent or assaultive behavior towards others? ◯ **Yes** ◯ **No**
If yes, please explain:

Mental Health Professional's Referral for Services continued

(To be completed by the mental health professional)

Rate the client on a scale of 1-5 (1=low, 5=high)

Desire for recovery from mental illness:	◯1 ◯2 ◯3 ◯4 ◯5
Desire to work a recovery related program:	◯1 ◯2 ◯3 ◯4 ◯5
Ability to deal with a less structured environment:	◯1 ◯2 ◯3 ◯4 ◯5
Likelihood of medication compliance:	◯1 ◯2 ◯3 ◯4 ◯5
Ability to get along with others in a community living environment:	◯1 ◯2 ◯3 ◯4 ◯5

- **Is the client currently a client of COCMHC?** ◯ **Yes** ◯ **No**
- **If no, where does the client currently receive outpatient services?**
- **If the client is discharging from an inpatient psychiatric hospitalization, where will their outpatient services be and the date of their next appointment/intake?**
- **Does the client have a source of income?** ◯ **Yes** ◯ **No**
- **If yes, please list the source of income:**
- **Any other pertinent information that may be helpful:**

Mental health professional signature: _____ **Date:** _____

Client Request for Services

(To be completed by the prospective client)

Client's Name (including maiden name):	Client's phone number:	Date:
Preferred name:	**Client's pronouns:**	**Client's marital status:**

Mental Health History

Please describe your mental health symptoms:	
How long have you been experiencing mental health concerns?	**Age of first treatment:**
What were the reason(s) you sought treatment?	**Number of inpatient psychiatric hospitalizations:**
Are your current mental health medications reducing your symptoms? ◯ **Yes** ◯ **No** **If no, please explain:**	
Do you take your medications as prescribed? ◯ **Yes** ◯ **No**	**If no, please explain:**
Do you experience any hallucinations? (audio, visual, olfactory, etc) ◯ **Yes** ◯ **No** **If yes, please explain:**	
Have you ever experienced suicidal or homicidal ideations? ◯ **Yes** ◯ **No** **If yes, please explain:**	**How many suicide attempts have you made in the last 5 years?**
What are your strengths?	**What coping skills do you utilize?**

Employment & Support

Do you have a source of income? (employment, SSI/SSDI, etc) ◯ **Yes** ◯ **No** **If yes, please explain the source of income and how much income per month:**	
Do you have personal forms of identification? (ID, social security card, birth certificate, etc) ◯ **Yes** ◯ **No** **If no, please explain:**	**Do you receive food stamps?** ◯ **Yes** ◯ **No**
Who makes up your support system?	

Client Request for Services continued

(To be completed by the prospective client)

Addiction History

Have you ever abused alcohol? ◯ **Yes** ◯ **No** **If yes, age of first use:**	**How long has it been since your last use of alcohol?**	
Have you ever used street/illegal drugs and/or abused prescribed medications? ◯ **Yes** ◯ **No** **If yes, age of first use:**	**How long has it been since your last use of illegal drugs and/or abused prescription medications?**	
Please indicate which substances you have used:		
Do you have a medical marijuana card? ◯ **Yes** ◯ **No**	**Is this something you are willing to forgo if accepted into the TLP?** ◯ **Yes** ◯ **No**	
Do you currently use tobacco? ◯ **Yes** ◯ **No** **If yes, age of first use:**	**Do you attend 12 step meetings?** ◯ **Yes** ◯ **No**	**How many times have you been in treatment for your substance use?**
Is there a history of behavioral addictions (Sex, gambling, shopping, porn, food, social media, etc.)? ◯ **Yes** ◯ **No** **If yes, please explain:**		

Legal History

Have you ever been arrested or charged with a crime? ◯ **Yes** ◯ **No**	**If yes, total number of arrests:** **Number of arrests in last year:**	**What state(s) are your charges in?**
Have you been convicted of any violent criminal charges or sex crimes? ◯ **Yes** ◯ **No** **If yes, please explain:**		
Total number of arrests due to drugs/alcohol?	**Total amount of time spent in jail/prison?**	
Do you have any outstanding warrants for your arrest? ◯ **Yes** ◯ **No** **If yes, please explain:**	**Are you currently involved with the court system? (Upcoming hearings, probation, etc.)** ◯ **Yes** ◯ **No** **If yes, please explain:**	

Client Assessment

(To be completed by the prospective client)

Please check the following areas in which you need help.

Management of mental illness: ☐ Managing feelings/emotions. ☐ Managing behaviors. ☐ Using coping skills. ☐ Taking medications as prescribed. ☐ Asking for help when needed. ☐ Maintaining feelings of self-worth. **List any issues related to mental illness:**	**Social skills:** ☐ Forming and maintaining healthy relationships. ☐ Setting healthy boundaries. ☐ Initiating contact with others. ☐ Communicating with others. ☐ Occupying free time. ☐ Experiencing enjoyment in life. ☐ Having fun. **List any issues related to social skills:**	**Life skills:** ☐ Maintaining personal hygiene. ☐ Cooking & regulating diet. ☐ Scheduling & receiving medical care. ☐ Finding and using community services. ☐ Doing laundry. **List any issues related to life skills:**
Thinking/mental processing: ☐ Processing information. ☐ Retaining information. ☐ Maintaining concentration. ☐ Learning new skills. ☐ Following directions. **List any issues related to thinking/mental processing:**	**Financial/work related skills:** ☐ Managing money. ☐ Budgeting & paying bills. ☐ Remaining punctual. ☐ Interviewing for jobs. ☐ Working with others. **List any issues related to financial/work:**	**Housing safety and security:** ☐ Maintaining a safe and clean apartment. ☐ Feeling safe and secure in your environment. ☐ Paying rent/utilities on time. ☐ Living with others. **List any issues related to housing safety and security:**

Client Assessment continued

(To be completed by the prospective client)

List the top 3 skills you would like to work on if accepted into the Transitional Living Program.

1)
2)
3)

Please check all that apply.

- ☐ **I believe that recovery is possible.**
- ☐ **I am committed to being honest with myself, staff, and fellow program participants when things are tough or I feel like: relapsing, not taking my medications, isolating, and/or giving up.**
- ☐ **I understand that part of the learning process involves staff holding me accountable to my goals and healthy behaviors.**
- ☐ **I understand that I have control over my recovery, and the results depend on the effort I put into it.**
- ☐ **I am committed to prioritizing my program and recovery over everything that may be a potential barrier.**
- ☐ **I am ready for change.**

Client signature: _____ Date: _____