



<u>Office Use Only:</u>
Accepted <input type="checkbox"/>
Denied <input type="checkbox"/>
Move in date: _____
Facility: _____

**Group Home Referral**

Date: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Person/Agency Inquiring: \_\_\_\_\_ Contact Information: \_\_\_\_\_

**Applicant Information**

Name of Applicant: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Insurance: Medicaid ID Number: \_\_\_\_\_ Other: \_\_\_\_\_

How will applicant pay Room & Board \$500.00/month plus \$150.00 Security Deposit?: \_\_\_\_\_

Does this person have a payee? No  Yes  If yes, please provide payee information:

Name of Payee: \_\_\_\_\_

Payee Address: \_\_\_\_\_

Payee Phone Number: \_\_\_\_\_

**\*We recommend residents use payee services in the beginning of our program to avoid being discharged for non-payment of rent. Winds of Change provides this service at no cost. There are additional payee services in the Missoula area as well.**

Applicant's Current Living Situation: \_\_\_\_\_

Applicant's Diagnosis: \_\_\_\_\_

Conditional Release/Community Commitment/Probation or Parole: No  Yes

Contact Person: \_\_\_\_\_

Criminal History: Violent  Sex

Drug and Alcohol Use: \_\_\_\_\_

Medical Conditions: (Allergies, Mobility, Dietary Needs, Etc.) \_\_\_\_\_

Does the applicant have a Guardian or Power of Attorney?

No  Yes  Contact Information: \_\_\_\_\_

**In order to be approved by Montana Medicaid for Adult Group Home placement, the applicant must meet SDMI criteria as described in the manual as well as functional impairments that require this level of care. Please provide as much detail as possible.**

**List all hospitalization information over the past three years:**

Facility Name	Admission Date	Discharge Date	Reason for Admission

**List all medications, including both psychiatric and medical:**

Medication	Dose	Schedule


**List specific reasons the applicant cannot succeed in a lower level of care:**

---



---



---



---



---

**Check all symptoms the applicant experiences:**

**Mood Problems:**

- Depression
- Bipolar Disorder/ Manic Depression
- Mania
- Sleep Problems
- Lack of Motivation
- Self-Harm, Cutting, or Burning
- Suicidal thoughts or Suicide Attempts
- Personality Disorder: \_\_\_\_\_

**Anxiety Problems:**

- Posttraumatic Stress Disorder (PTSD)
- Flashbacks
- General Anxiety
- Panic Attacks
- Social Anxiety or Social Phobia
- Obsessive Compulsive Disorder
- Bulimia, Binge Eating, or Anorexia

Personality Disorder: \_\_\_\_\_

**Psychosis Problems:**

- Schizophrenia
- Schizoaffective
- Paranoia
- Delusions
- Visual Hallucinations
- Auditory Hallucinations
- Catatonic
- Personality Disorder: \_\_\_\_\_

**What impact do the above symptoms have on the applicant's daily activities? (Please list all functional, occupational, and social impairments):**

---



---



---



---



---

**Describe any lack of family or other community or social supports:**

---

---

---

---

---

**Due to the applicant's diagnosis, list how they exhibit an impaired ability to perform daily living activities in an appropriate manner:**

---

---

---

---

---

**Any additional comments:**

**In addition to this referral, please also submit recent clinical and/or psychiatric assessments and progress notes that describe the applicant's mental health information at this time.**

**If you cannot submit this completed referral and additional information requested you may do so by fax, email or mail:**

**Fax-**to Brandi Baker at 1-406-327-0042

**Email-**Brandi Baker [bbaker@windsofchangemontana.com](mailto:bbaker@windsofchangemontana.com)

**Mail-**Wind of Change Attn: Brandi Baker 1120 Cedar Street, Missoula, MT 59803