



<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: _____

Email: _____

Applicant Information

Name of Applicant: _____ Date of Birth: _____

Applicant Contact Number: _____

Email: _____

Social Security Number: _____

Insurance: Medicaid ID Number: _____ Other: _____

How will applicant pay Room & Board \$525.00/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: _____

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(List 3 Minimally)

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

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:

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.

Applications will not be accepted with missing information. By checking boxes you acknowledge that you have attached the following with application: *State Plan LOI*

Recent Clinical/ Psychiatric Assessments *Progress Notes*

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

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