Office Use Only:
Accepted ☐
Denied ☐
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 $600.00/month plus $500.00 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: _____

Is the Client Medically Stable? No ☐ Yes ☐

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 Ashlynn Noble at 1-406-327-0042

Email- anoble@wocmt.com

Mail-Wind of Change Attn: Ashlynn Noble PO Box 16446, Missoula, MT 59808

Print Form