



TRANSITIONAL VOUCHER PURCHASE REQUEST

Client Data											
SSN:		County of Residence:									
Last Name:		Primary Insurance:									
First Name:		Legal Custodian's Name:									
Middle Initial:		Legal Custodian's Phone Number:									
Gender:	Male <input type="checkbox"/> Female <input type="checkbox"/>	Legal Custodian's Address:									
Date of Birth:		Current Mental Health/Substance Abuse Provider:									
What other funding streams have been explored?											
Other services already in place? If yes, which ones? (e.g. outpatient counseling, med mgmt.)											
Total monthly income: \$ _____ Source(s) of income: _____											
Has this person applied for SSI/SSDI? <input type="checkbox"/> Yes, Date: _____ <input type="checkbox"/> No											
Has this person been referred to a SOAR Processor? <input type="checkbox"/> Yes, Name of SOAR Processor: _____ <input type="checkbox"/> No											
Benefits (Insurance/Food Stamps/Other Subsidies): _____											
Please list all Mental Health, Substance Abuse, and Physical Health Diagnoses:											
Part I – Initial Screening –Eligibility											
<b>The consumer must meet the following criteria:</b> 1. A current mental health diagnosis <b>and/or</b> 2. A current substance abuse diagnosis <b>and</b> 3. Must meet at least one of the following: a) Experiencing Homelessness b) Receiving Care Coordination c) Participating in FACT Teams			<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;">Yes</th> <th style="width: 50%;">No</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yes	No										
<input type="checkbox"/>	<input type="checkbox"/>										
<input type="checkbox"/>	<input type="checkbox"/>										
<input type="checkbox"/>	<input type="checkbox"/>										
<i>*LSFHS will review the referral and determine if it meets all eligibility criteria</i>											
Part II – Service Requested											
Type of Service (choose <b>only</b> one): Housing Subsidy Child Care Vocational Services Pharmaceuticals Time-Limited Transportation Housing Assistance Clothing Educational Services Medical Care Other	<b>If requesting ALF or group home funding:</b> Does the owner live in the facility?      Yes    No  How many people live in the facility (not including embers or relatives)?  Are there any residents received OSS payments?      Yes    No  Does the staff provide one or more personal Care Services related to residents on a 24-hour Basis (supervisor assistance with bathing, dressing, eating, toileting, hygiene, and/or medications?)      Yes    No	<b>Treatment/Service Plan Goal to Address with this funding (send copy of treatment/service plan if available):</b>									
Estimated Cost of Service:		Vendor to Provide Service:									
Frequency of Service (ex. daily, weekly, monthly, one-time):		Vendor Credentials (ex. W-9, professional credentials):									
Start Date of Service:		Vendor Telephone Number:									
End Date of Service:		Vendor Address:									
Requestor Data											
Form completed by:		Date:	Agency:								
Address:		Telephone Number:									
Fax Number:		Email:									
This section to be completed by LSF: (ONLY for those purchases in excess of \$1,000 and ALF Requests)											
<b>ALF Requests Only:</b>	<b>Documentation showing due diligence was exercised in searching for less restricting housing in these cases submitted to DCF?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Date of DCF Approval: _____ Name of DCF Approver: _____										
The requested services has been: Approved <input type="checkbox"/> Denied <input type="checkbox"/>		Bill to (circle one): MHTRV    MSTRV    MHDRF									
Comments:											
_____ LSFHS Representative		_____ Date									
_____ Director of Program Operations or Regional Director of SOAR and Housing Initiates		_____ Date									