EXHIBIT A

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 ☐ Female ☐	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? ☐Yes, Date: ___________ ☐No
Has this person been referred to a SOAR Processor? ☐Yes, Name of SOAR Processor: __________ ☐No
Benefits (Insurance/Food Stamps/Other Subsidies): ___________________________

Please list all Mental Health, Substance Abuse, and Physical Health Diagnoses:

Part I – Initial Screening –Eligibility

The consumer must meet the following criteria:	**Yes**	**No**
1. A current mental health diagnosis **and/or**	☐	☐
2. A current substance abuse diagnosis **and**	☐	☐
3. Must meet at least one of the following: a) Experiencing Homelessness b) Receiving Care Coordination c) Participating in FACT Teams		☐

**LSFHS will review the referral and determine if it meets all eligibility criteria*

Part II – Service Requested

Type of Service (choose **only** one):	**If requesting ALF or group home funding:**			**Treatment/Service Plan Goal to Address with this funding (send copy of treatment/service plan if available):**
Housing Subsidy	Does the owner live in the facility?	Yes	No	
Child Care Vocational Services	How many people live in the facility (not including embers or relatives)?			
Pharmaceuticals Time-Limited Transportation	Are there any residents received OSS payments?	Yes	No	
Housing Assistance Clothing Educational Services Medical Care Other	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	

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)

ALF Requests Only: **Documentation showing due diligence was exercised in searching for less restricting housing in these cases submitted to DCF?** Yes ☐ No ☐ Date of DCF Approval: Name of DCF Approver:

The requested services has been: Approved ☐ Denied ☐ Bill to (circle one): MHTRV MSTRV MSTV2 MHDRF

Comments:

______________________________ LSFHS Representative	______________________________ Date
______________________________ Director of Program Operations or Regional Director of SOAR and Housing Initiates	______________________________ Date