

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/Substa Provider:	nce Abuse				
What other funding streams have	been exp	ored?			1					
Other services already in place? I										
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 d	-									
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										
4. A Housing Checklist has been completed for Housing Subsidy requests *I SEHS will review the referral and determine if it meets all eligibility criteria.								N/A		
*LSFHS will review the referral and determine if it meets all eligibility criteria Part II – Service Requested										
								ddross with		
Housing Cubridy					this funding (send conv of treatment/service					
Child Care Does the owner live in the facility? OYes ONC						plan if available	• •	,		
Vocational Services How many people live in the facility							•			
Pharmaceuticals (not including embers or relatives)?										
That indeed could be a second of the country of the										
Time-Limited Transportation Housing Assistance	Yes									
Clothing	OSS payments?									
Educational Services	Does the staff provide one or more personal									
Medical Care	Care Services related to residents on a 24-hour									
Other		asis (supervisor assistance with bathing, Yes No								
Other 🔲	dressing, eating, toileting, hygiene, and/or medications?)									
5.:										
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:		Da	te:		Agency:					
Address:				Telephone Number:						
Fax Number:					nail:					
This section to be completed by LSF: (ONLY for those purchases in excess of \$1,000 and ALF Requests)										
ALF Requests Only:	Docume	ntation show	ing due dil	ligen	ce was exercised in searching fo	r less restrictin	g housing in thes	se cases		
ALI Requests omy.		ed to DCF? Yes		Ŏ	Date of DCF Approval:	Name of DCF	_			
				<u> </u>						
The requested services has been: Approved Denied Bill to (circle one): MHTRV MSTRV MSTV2 MHD								MHDRF		
Comments:										
		_								
LSFHS Representative						Date				
Director of Program Operations or Regional Director of SOAR and Date										
Director of Program Operations or Regional Director of SOAR and Housing Initiates Date										