Adult Services Team Staffing Form

Referral Date ___/___/_____ Staffing Sponsor _____

Agency _____

Name _____

Last First Middle Suffix (Jr. SR. III etc.)

Other Names Used? _____

Current address_____

Gender: ☐ Male ☐ Female Date of Birth: ___/___/_____ (mm/dd/yyyy) Age ___ Do you have an ID? ☐ Yes ☐ No

Social Security # _____-_____-_____ Veteran? ☐ Yes ☐ No If yes, which branch? _____

Date of Service _____ What is your ethnicity? _____ Do you have a phone? ☐ Yes ☐ No

If yes, number ___-___-____ **County of Last Permanent Residence _____ Zip Code_____**

(County and state and zip code where you last had a permanent stable home)

Are there other members of your household needing services? ☐ Yes ☐ No

Name _____ DOB___/___/____ Relationship_____
Last First Middle Social Security # _____-_____-_____

Name _____ DOB___/___/____ Relationship_____
Social Security # _____-_____-_____

Name _____ DOB___/___/____ Relationship_____
Social Security # _____-_____-_____

Name _____ DOB___/___/____ Relationship_____
Social Security # _____-_____-_____

Emergency Contact: Name and Relationship: _____

Contact Address:_____ Contact Phone _____-____-_____

Obtained authorization to release protected information: ☐ Yes ☐ No

Person agrees to participate in the staffing: ☐ Yes ☐ No

Prior Living Situation (The most recent situation)	**Chronic Homelessness**
☐ Non-Housing (street, Park, car, bus station, ect)	Length of stay in prior living situation?
☐ Emergency Shelter	☐ Currently in housing
☐ Transitional housing for homeless	☐ 1 week or less
☐ Permanent housing for homeless	☐ More than a week less than a month
☐ Living with Relatives	☐ 1-3 months
☐ Living with friends	☐ 3 months to a year
☐ Rental Housing	☐ 1 year or longer
☐ Owned home or apartment	☐ unknown
☐ Hotel or motel (not paid with voucher)	How many times have you been homeless during the last 3 years, including today? _____
☐ Foster home or group home	**If in an institution, how long was the stay?**
☐ Other (explain)_____	*☐ Less than 30 days
☐ **Institution –indicate type below:**	☐ More than 30 days
☐ Psychiatric facility	☐ More than 180 days
☐ Substance abuse treatment facility	*If the guest stayed less than 30 days in an institution also check where the guest lived before the institution.
☐ Hospital	
☐ Jail/Prison	

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Monthly Household Income	**Applied for**	**Receive**	**Non Cash Benefits** (x all that apply)	**Applied for**
☐ Earned Income	☐	$_____	☐ Food Stamps	☐
☐ Unemployment	☐	$_____	☐ TANF Child Care Service	☐
☐ SSI	☐	$_____	☐ TANF Transportation Services	☐
☐ SSDI	☐	$_____	☐ Other TANF funded Services	☐
☐ SS Retirement	☐	$_____	☐ Medicaid / OHP Insurance	☐
☐ Private Disability	☐	$_____	☐ Medicare Insurance	☐
☐ Workers Compensation	☐	$_____	☐ Private Insurance	☐
☐ TANF	☐	$_____	☐ Other Public Insurance	☐
☐ General Assist.	☐	$_____	☐ Rent Subsidy (source)_____	☐
☐ Veterans Disability	☐	$_____	☐ Other Sources_____	☐
☐ Veterans Pension	☐	$_____		
☐ Employee Pension	☐	$_____	**Employment**	
☐ Child Support	☐	$_____	Can you work? ☐ Yes ☐ No	
☐ Alimony/spousal	☐	$_____	Are you employed? ☐ Yes ☐ No	
☐ Student Aid	☐	$_____	Employer? _____	
☐ Other _____	☐	$_____	Hours per week? _____	
Total income		**$_____**	Phone # (____)____-_____	
			Previous Occupation_____	
Financial Liabilities	**Total Due**	**Monthly payments**	If unemployed, how long? _____	
☐ Court Fines	$_____	$_____		
☐ Garnishments	$_____	$_____	**Mode of Transportation**	
☐ Child Support	$_____	$_____	☐ Car	
☐ Alimony	$_____	$_____	☐ Bike	
☐ Other debt	$_____	$_____	☐ Walk	
Total liabilities	**$_____**	**$_____**	☐ Public Transportation	

Criminal History	
Felony Conviction ☐ Yes ☐ No	For what offense_____
Are you a registered sex offender ☐ Yes ☐ No	
Currently on Parole/Probation? ☐ Yes ☐ No	
If yes, Parole Officer _____ Name Phone # County	
Education	
What is the highest level of education completed?	_____
Do you have other Vocational training or skills?	_____

Housing
Have you ever applied for Section 8 before? ☐ Yes ☐ No Where _____ When _____
Have you ever been convicted of manufacturing methamphetamine in a federally assisted unit? ☐ Yes ☐ No
Have you ever been evicted (FED)? ☐ Yes ☐ No If yes, why? _____ When _____
Are you currently on the Section 8 wait list? ☐ Yes ☐ No If yes, when? _____

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Special Needs	(Problems that may affect housing-this is not a diagnosis. Check all that apply)
General Health ☐ Excellent ☐ Very Good ☐ Fair ☐ Poor ☐ Don't Know	

Do you have a disabling condition? ☐Yes ☐ No ☐ Unknown	
☐ Alcohol Abuse	☐ Domestic Violence
☐ In treatment/recovery	When did it occur?
☐ Impairs ability to live independently	☐ Within past 3 months
☐ Do you want treatment	☐ 3-6 months ago
	☐ 6 months to a year
☐ Drug Abuse	☐ More than a year ago
☐ In treatment/recovery	☐ Unknown
☐ Impairs ability to live independently	
☐ Do you want treatment	☐ Pregnancy Due date:_____
	☐ HIV/AIDS
☐ Developmental/learning disability	
☐ Mental Illness (mental health issue)	
What kind?_____	
☐ In treatment/recovery	
☐ Impairs ability to live independently	
☐ Do you want treatment	
☐ Physical/sensory disability	
Accommodations needed: _____	

Current or past mental health or alcohol and drug treatment provider?_____
Do you have a Primary Care Physician? ☐ Yes ☐ No Name_____

Medications

Medication	Prescriber	Reason

Language

☐ Non-English Speaking Language spoken: _____ Do you need an interpreter ☐ Yes ☐ No

☐ Do you need assistance filling out forms? ☐ Yes ☐ No

What outcome(s) do you envision from this staffing?

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Notes: (What is your overall assessment of this person or special considerations)

Please attach any pertinent documents if available.

Please email a copy of the AST Staffing Form to ast@co.linn.or.us AND forward the original, signed copy and a signed information release form by Fax (541-928-3020), mail (Linn County Mental Health Attn: AST P.O. Box 100 Albany, OR 97321) or deliver to Linn County Mental Health, 445 Third Ave SW Albany, OR.

Signature of Sponsor: _____

Sponsor contact information: _____

Phone email