

Pathway Homes, Inc.
10201 Fairfax Blvd., Suite 200
Fairfax, VA 22030-2209



GENERAL ADMISSIONS CRITERIA:

Each individual considered for admission to any of Pathway Homes' programs *must*:

- ◇ be a resident of Fairfax County, or the cities of Fairfax or Falls Church
- ◇ be at least 18 years of age
- ◇ have a serious and persistent mental illness
- ◇ not be a danger to oneself or others
- ◇ not actively be abusing alcohol or other substances

GENERAL PROGRAM PURPOSE:

To provide residential mental health support services to individuals with a serious mental illness. To provide the structure, supervision, and support which are desired and needed in learning the life skills necessary for successful community living.

Group Homes:

Admissions Criteria: Resident must be willing to participate in all recommended mental health services, and must be willing to live with roommates. Resident must also be motivated to live in a community group home, and receive intensive support services.

Services Provided: 24 hour per day, seven day a week supervision, crisis intervention, case management, support in developing daily living skills, such as: budgeting, medication management, and conflict resolution.

Semi-Independent Program:

Admissions Criteria: Individuals must be motivated to live independently, possess basic daily living skills, and be able to manage medications reliably.

Services Provided: Houses vary in staff supervision, ranging from those with 15 hours per week of staff support to those with 20 hours per week of staff support.

McKinney Program for the Homeless:

Admissions Criteria: In addition to the semi-independent criteria (above), applicant must meet the federal criteria for homelessness. Such criteria primarily includes having previously lived in a homeless shelter, on the street, or in transitional housing.

Services Provided: Houses vary in staff supervision, ranging from those with 15 hours per week of staff support to those with 20 hours per week of staff support.

Supported Housing:

Admissions Criteria: Consumer has own independent housing.

Services Provided: Drop-in counseling services are provided on an as-needed basis.

SHOP (Supported Housing Options Program):

Pathway Homes, Inc. works in concert with the Fairfax-Falls Church Community Services Board to help consumers obtain and maintain independent housing. A separate application is filled out by the consumer. Please contact Pathway Homes' office at (703) 876-0390 for an application.

Pathway Homes, Inc.
10201 Fairfax Blvd., Suite 200
Fairfax, VA 22030-2209



APPLICATION FORM

PART I: TO BE COMPLETED BY REFERRING WORKER

Referral is For: (See attached description/Check all that apply):

- 24 hr supervised group home**
- Semi-independent housing**
- McKinney Homeless Program** (client currently in transitional housing/homeless shelter/at no fixed address)
- Supported Living Program** (client has own living situation)

A. Referral Information

Agency: _____ Date of Referral: _____
Name: _____ Phone: _____

B. Client Information

Name: _____ DOB: _____ Sex: M ___ F ___
Present Address: _____ Soc. Security #: _____
_____ Phone: _____

Program Name (please specify if transitional, group home, shelter, etc.):

Primary Therapist (if different from referral source): _____
Agency/Address: _____ Phone: _____

Other agencies involved with client (include primary worker and phone number):

Source and Amount of Income: _____

Medicaid#: _____ Expiration Date: _____

Other Insurance: _____

Legal History (convictions, probations, dismissal, etc.):

U.S. Citizen: Yes _____ No _____ (please list country of citizenship if "No") _____

Ethnic Background: (Check one):

- _____ Native American (American Indian/Alaskan Native)
- _____ Asian or Pacific Islander
- _____ Black/African American (not Hispanic in origin)
- _____ Hispanic/Latino
- _____ Caucasian (non-Hispanic)
- _____ Other (specify) _____

Primary Language (if not English) _____

Previous Military Service Yes: _____ No: _____

C. Presenting Problem

Diagnosis: Axis I _____ Axis I _____
Axis II _____
Axis III _____
Axis IV _____ Axis V _____

Please describe client's past and current level of functioning in the following areas:

Vocational/Day Activity (please include work history and current daily activity):

Social/Leisure:

Interpersonal:

Residential History (please include residential information, not including hospitalizations, for the past 5 years):

Reason for referral to supervised housing:

Other residential programs to which client has currently applied:

Please assess client's skills in the following areas:

<i>SKILLS</i>	<i>NONE</i>	<i>POOR</i>	<i>GOOD</i>	<i>EXCELLENT</i>
Personal Hygiene				
Cooking/Nutrition				
House Cleaning				
Getting up in AM				
Medication Mngmnt.				
Budgeting				
Grocery shopping				
Public Transportation				
Interpersonal/Social				
Treatmt. Compliance				
Attends Day Activity				

Comments on independent living skills:

Client's Strengths:

Client's Goals:

D. Behavioral History

SUBSTANCE USE PROFILE:

Please complete each column for each type of substance used:

<i>Type</i>	<i>Onset of Use</i>	<i>Frequency</i>	<i>Quantity</i>	<i>Method of Administration</i>	<i>Date of Last</i>	<i>Use</i>

Treatment received for substance abuse:

PLEASE DESCRIBE CLIENT'S BEHAVIOR IN THE FOLLOWING AREA (including dates of behavior):

Suicide attempts/Self-injurious behavior:

Verbal or physical aggression:

Sleeping difficulties:

Eating-related difficulties:

DOES CLIENT EXPERIENCE:

___ Thought Disorder ___ Anxiety Attacks ___ Hallucinations ___ Delusional Thinking

MEDICATION PROFILE:

Current medication noted (name, dosage, route):

Non-psychiatric medications (including OTC meds):

Does client take medication reliably without supervision? Please describe/explain:

Please list and describe effects (positive or negative reactions) to past medications used for treatment:

PLEASE PROVIDE PERTINENT PAST AND PRESENT MENTAL STATUS INFORMATION:

Past:

Present:

Signs and symptoms of decompensation:

E. Treatment History

PLEASE INCLUDE INPATIENT/OUTPATIENT PSYCHIATRIC, SUBSTANCE ABUSE, AND OTHER MEDICAL ADMISSIONS RELATED TO PSYCHIATRIC PROBLEMS OR SUBSTANCE ABUSE

<i>LOCATION</i>	<i>INPATIENT OR OUTPATIENT</i>	<i>DATES OF ADMISSION/DISCHARGE</i>	<i>REASON FOR TREATMENT</i>

F. Medical Information

Current physical conditions:

Past serious illnesses (client and family):

Drug Allergies: No _____ Yes _____

Drugs(s) _____

Date of use _____

Type of reaction _____

Date of last physical examination: _____ TB test results (*if known*): _____

Medical M.D.: Name: _____ Phone: _____

Psychiatrist: Name: _____ Phone: _____

G. Family Information

Emergency Contact Name: _____

Address: _____ Relationship to client: _____

_____ Phone: _____

Family Names/Relationships (also include significant others):

Degree and Nature of Family Involvement:

PART II: TO BE COMPLETED BY APPLICANT

Name: _____

Please respond to the following questions:

1. Why do you wish to enter Pathway Homes, Inc. Supervised Residential Program?

2. Which areas of independent living would you like to receive help with in Pathway Homes' programs?

3. Please rate your skills in the following areas:

<i>SKILLS</i>	<i>NONE</i>	<i>POOR</i>	<i>GOOD</i>	<i>EXCELLENT</i>
Personal Hygiene				
Cooking/Nutrition				
House Cleaning				
Getting up in the A.M.				
Grocery Shopping				
Budgeting				
Public Transportation				
Medication Mgmt.				
Getting along w/ Others				
Treatment Compliance				

4. What are some of your interests and talents?

5. Describe your use of alcohol and/or drugs. Please include which substances you use(d), how much, how often and how long you used (or have been using) them.

6. Have you ever received treatment for the abuse of alcohol or drugs? If yes, please describe.

7. What are your short term goals?

8. What are your long term goals?

9. What other things would you like us to know about you?

Please note: We ask that all additional information such as intakes, psychosocial histories, hospital discharge summaries and psychological tests be sent along with this application to the Pathway Homes main office. New applications are reviewed by an Admissions Committee on the third Thursday of each month, during which the committee assigns each suitable candidate to a waitlist for one of our housing programs. At such time that there is an opening for one of the relevant programs, we will notify the referral source and/or candidate to set up an interview.

Consent to Exchange Information

I hereby authorize Pathway Homes, Inc., to exchange information concerning me with any of the **service providers** listed in either Part I or Part II of this application. I understand that this information will be exchanged only to assess my suitability for residential services.

This consent will automatically expire upon revocation by client.

_____ Applicant Signature	_____ Date
_____ Witness Signature	_____ Date

Consent to Exchange Information

I hereby authorize Pathway Homes, Inc., to exchange information concerning me with any of the **family members/significant others** listed in either Part I or Part II of this application. I understand that this information will be exchanged only to assess my suitability for residential services.

This consent will automatically expire upon revocation by client.

_____ Applicant Signature	_____ Date
_____ Witness Signature	_____ Date