Applying for Transition House

Welcome to Transition House, Inc. Before you begin the application process here are a few things for you to consider:

- ☐ You must be 18 years old or older
- ☐ You must be seriously mentally ill as defined by the Oklahoma Department of Mental Health and Substance Abuse Services and determined by a Licensed Behavioral Health Professional.
- ☐ You must need rehabilitation or assistance in the following skill areas:
    - Daily Living and Community Living Skills
    - Social and Recreational Skills
    - Pre-Vocational and Vocational Skills
    - Self-Esteem, Communication, and Building Healthy Relationships
    - Advocacy
- ☐ You are motivated and committed to your Mental Health Recovery.
- ☐ You are willing to maintain medication compliance and have the ability to self-administer medication.
- ☐ You have had a negative Tuberculosis test in the past 6 months or are able to provide documentation from a health professional stating you are able to live in a communal living situation.
- ☐ You have no recent history of alcohol or other substance abuse.
- ☐ You have the skills and are willing to maintain your sobriety.
- ☐ You haven't been convicted of violent crimes against others.
- ☐ You are able to live in a supportive environment without 24 hour/day supervision.
- ☐ You are willing to follow agreements, policies and procedures of Transition House, Inc. program.
- ☐ Clients of Central Oklahoma Community Mental Health Center and Griffin Memorial Hospital will be given priority in consideration.

Transition House, Inc. reserves the right to refuse to provide services to those who:

- ☐ Do not have a serious mental illness
- ☐ Present an immediate risk to Staff, Volunteers, and/or Clients
- ☐ Have intellectual and/or psychiatric impairments that would preclude them from fully participating in the program or functioning independently
- ☐ Are married or related to any member of staff or Board of Directors
- ☐ Are married or related to another person in the Transitional Living Program
- ☐ Are solely in need of shelter

Transition House, Inc. reserves the right to ban individuals from the agency and all of its property who display behaviors that place the agency, Board of Directors, staff, and/or program participants at risk.

Transition House, Inc. Screening Process

Application

The application can be found on our website (www.thouse.org) or Transition House, Inc. office located at 700 Asp Ste. 2 Norman, OK.

The application has four parts:

1. **Clinician Referral** for Services to be completed by the Clinician (4.3)
2. **Client Request for Services** to be completed by Client (4.4)
3. **Client Assessment** to be completed by Client (4.4)
4. **Consent for Release of Confidential Information** allowing Transition House, Inc. to obtain: (4.6)
    - **a.** Psychosocial and/or Psychiatric Evaluation
    - **b.** Recent Assessment and Treatment Plan
    - **c.** TB test results done within the past 6 months
    - **d.** Pertinent Medical Records
    - **e.** Recent Progress Notes

Once the application is complete it can be faxed to Clinical Director (405) 360-2339, dropped off or mailed to the address listed above.

If you have any questions regarding the application process please feel free to call Clinical Director at (405) 360-7926.

Interview

1. Clinical Director will contact client and/or clinician to set up interview when there is a program opening.
2. Client will meet with Clinical Director and a Recovery Coordinator to complete interview questions.
3. Client will also be required to attend two groups.

Acceptance or Deferment

After client has completed the interview requirements, the clinical team will meet to discuss client's placement.

The client and/or clinician will be notified of the decision.

If client is accepted, the Recovery Coordinator will set up a time for the client's orientation and a move-in date will be determined. (Move-ins will typically occur on Mondays or Tuesdays.)

Additional information on the Transitional Living Program can be found in the Client Handbook, also found on the website.

700 Asp, Suite 2 – Norman, OK 73069 – (405)360-7926 – www.thouse.org

Clinician's Referral for Services

Client's First, Middle, and Last Name:	Date of Birth:	Age:	Date of Referral:

Referral Source:	Clinician Name:	Agency:
	Phone #:	Fax #:

Diagnosis
(Include Diagnostic Impressions and Current Medical Conditions)

Axis I:	GAF/LOF:
Axis II:	
Axis III:	

Current Medications

Mental Health History

Age of Onset:	Number of Psychiatric Hospitalizations:
Alcohol and/or Substance Abuse ◯ Yes ◯ No	If yes, date of last use:
Does the client have a history of violent or assaultive behavior against others? ◯ Yes ◯ No	
If yes, please explain:	

On a Scale of 1-5 (1=low, 5=high) Rate the Client's:

Desire to Recover from Mental Illness:	◯1 ◯2 ◯3 ◯4 ◯5
Ability to Deal with a Less Structured Environment:	◯1 ◯2 ◯3 ◯4 ◯5
Likelihood of Medication Compliance:	◯1 ◯2 ◯3 ◯4 ◯5
Ability to Get Along With Others in a Community Living Environment:	◯1 ◯2 ◯3 ◯4 ◯5

Current Client of COCMHC? ◯ Yes ◯ No If No, date of Intake or where the client will be receiving Outpatient Mental Health Services:	Does the Client have a source of income? ◯ Yes ◯ No If Yes, please list the source:

Please Include the Following with this Referral:

☐ Client Request for Services (completed by Client) ☐ Client Assessment (completed by Client)
☐ TB Test Results
☐ Copy of the Consent to Release Information signed by the client that allows Transition House, Inc., access to the client's Psychosocial History, Recent Assessments and Treatment Plans, Pertinent Medical Records, Recent Progress Notes.

Clinician Signature:	Date

CLIENT REQUEST FOR SERVICES

TO BE COMPLETED BY CLIENT

Name:	Phone #:	Date:

Mental Health History

Describe your mental health problems:	
How long have you been experiencing mental health problems?	Age of 1st Treatment?
Reason(s) you sought treatment?	
Are your mental health medications currently reducing your symptoms? ☐ Yes ☐ No ☐ Unsure	
If no/unsure, please explain:	
How many times have you been in the hospital?	
Do you have or have you ever had thoughts of harming yourself? ☐ Yes ☐ No	How many attempts have you made in the last 5 years?
Please explain:	

SUBSTANCE ABUSE HISTORY

Have you ever abused alcohol? ☐ Yes ☐ No		How long has it been since you last used alcohol?	
Have you ever used street/illegal Drugs or abused prescribed medications? ☐ Yes ☐ No		How long has it been since you last used drugs?	
Please indicate which drugs you have used:			
Longest period of sobriety?		How long ago was this?	
Do you attend 12 Step Meetings?	How many each week?	Do you have a Sponsor?	How many times have you been in treatment?

LEGAL HISTORY

Have you ever been arrested or charged with a crime? ☐ Yes ☐ No	If yes, total # of arrests during your lifetime:
Total number of arrests due to drugs/alcohol?	Total amount of time spend in jail or prison?
Are you currently facing any charges or are there any warrants issued for your arrest? ☐ Yes ☐ No	Have you been or are you currently Involved with the court system? ☐ Yes ☐ No
If YES to either of the last two questions please explain:	

EMPLOYMENT AND SUPPORT

Do you have a source of income? ☐ SSI/SSDI ☐ VA ☐ Employment ☐ Food Stamps ☐ Other ☐ None
If Employed, please state where you work and work schedule:
Who makes up your support system?

CLIENT ASSESSMENT

CHECK THE FOLLOWING AREAS IN WHICH YOU NEED HELP AND/OR ARE READY TO CHANGE:

Need Help	Ready to Change	Skill Development Area:
		Management of Mental Illness
☐	☐	Reduction of symptoms of my mental illness
☐	☐	Ability to Cope with Emotions/Manage Behavior
☐	☐	Ability to Identify and Understand Problem Areas
☐	☐	Knowing when to Ask for Help and the Ability to Do So
☐	☐	Managing Feelings
☐	☐	Medication Compliance
☐	☐	Self-Esteem
		Housing Safety & Security
☐	☐	Maintain a safe and clean apartment
☐	☐	Feeling Safe and Secure in your own Environment
☐	☐	Cooking
☐	☐	Doing Laundry
		Physical Care & Wellness
☐	☐	Hygiene
☐	☐	Nutrition
☐	☐	Medical Care
		Financial Stability
☐	☐	Money Management
☐	☐	Budgeting and Paying Bills

Need Help	Ready to Change	Skill Development Area:
☐	☐	Using the Bank
☐	☐	Shopping
☐	☐	Work Related Skills
☐	☐	Job Interviewing Skills
☐	☐	Attendance and Punctuality
☐	☐	Working with Others
☐	☐	Following Instructions
		Social & Interpersonal Relationships Skills
☐	☐	Experience Enjoyment in Life
☐	☐	Occupying Free Time
☐	☐	Having Fun
☐	☐	Making Plans and Carrying them out with Others
☐	☐	Healthy Social Interactions
☐	☐	Forming and Maintaining Healthy Relationships
☐	☐	Initiating Contact with Others
☐	☐	Communication Skills
☐	☐	Reduction of Isolation
☐	☐	Finding Ways to Get Around
☐	☐	Riding the Bus
☐	☐	Finding and Using Community Services

LIST THE TOP THREE SKILLS YOU WOULD LIKE TO WORK ON IF ACCEPTED INTO THE TRANSITIONAL LIVING PROGRAM:

1.

2.

3.

PLEASE CHECK ALL THAT APPLY:

- ☐ I believe Recovery is possible.
- ☐ I understand the Recovery Process has its ups and downs. I commit to being honest with myself, staff, and fellow program participants when things are tough or I feel like: relapsing, not taking my medications, isolating, and/or giving up.
- ☐ I understand that part of the learning process involves staff holding me accountable to my goals and healthy behaviors.
- ☐ I am ready for change!

Client Signature:	Date:

This facility does not permit discrimination because of age, gender, race, religion, color, creed, sexual orientation, place of national origin, disability, or inability to pay.