Mental Health Treatment Verification

Pioneer Transition House

Client name: _____

Mental Health Eligibility Screening

☐ Currently Accessing Mental Health Services

Mental Health Provider: _____ Phone #: _____

Release of Information (ROI) YES ☐ NO ☐

☐ Client identifies as having Mental Health issues and will need assistance to access services. **(You must include a brief description of client behaviors or symptoms below)**

☐ Referral due to Mental Health concerns. Resulting behaviors are creating a barrier to stable housing. **(You must include a brief description of client behaviors or symptoms below)**

BRIEF DESCRIPTION OF BEHAVIORS:

Housing Status

Describe current housing situation (where client is staying, how long they can be there, any information regarding why it is an unstable living situation):

Staff name and title: _____

Organization: _____

Staff signature: _____ Date: _____