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: __________________