PIONEER
HUMAN SERVICES
A CHANCE FOR CHANGE

Pioneer Transition House

Referral Form

Voice: 360-336-0116
Fax: 360-336-0117

Pioneer Transition House is a ten (10) bed, co-ed recovery based program to address barriers to permanent housing and self-sufficiency. Residency is month to month without a maximum length of stay. As part of our program, all clients who participate will have individual goals, requirements, and a service plan in place with community Case Manager or Counselor that articulates their commitment to address their barriers. Transition House provides referrals to community services.

Program Criteria:

- Must be a **Skagit County resident** (accessing services in Skagit County for at least 1 year)
- Must have mental health and/or substance abuse diagnoses with verification of treatment (inpatient/ outpatient)
- Must be referred by a higher level of care (i.e. jail, prison, crisis center, inpatient treatment facility, etc.)
- Must provide verification of homelessness (form included in referral)
- Must be linked to Case Manager or Counselor at time of program entry.

Basic Rules and Program Expectations:

- Residents must pay a service fee (30% of income not to exceed $450 per month or provide zero income verification)
- Complete basic daily chores, meal preparation, and participate in community living with minimal staff oversight.
- Threats or acts of violence are **not** allowed and drug/alcohol use (including marijuana) ON or OFF premises is not tolerated.
- Clients are required to participate in Mental Health or Chemical Dependency outpatient treatment, whichever may apply.

Completed Referral Includes:

- Referral Form (please have a service provider complete, not the client)
- Completed Verification of Homelessness
- Completed Mental Health Treatment Verification and/or Chemical Dependency Verification
- Completed Resident Confidential Information
- Please fax referrals to (360) 336-0117. Call if you have any questions.

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Case Manager or Counselor referring agency: _____

Agency: _____

Phone: _____ Fax: _____

Email: _____

Name of referral: _____

When will your referral be able to start residency: _____/_____/_____

****Community Case Manager or Counselor providing ongoing services****:

_____

Name **Phone**

Please tell us about your client:

Housing history (Past residency, history of homelessness):

_____

_____

_____

Entitlements (SSI, SSDI, Food Benefits, Medical):

_____

_____

_____

Debt/Evictions/Money Management (Any outstanding rent due or bills in collections, issues with gambling?):

_____

_____

_____

Basic Needs (transportation, food, clothing, etc.):

_____

_____

_____

Legal (criminal history, immigration status, outstanding warrants):

_____

_____

_____

Mental Health (Provide diagnoses. Are they currently engaged in outpatient services?):

_____

_____

_____

Substance Use/ Chemical Dependency (Provide diagnoses. Are they currently engaged in outpatient services?):

_____

_____

_____

Financial (Any form of income? Does the referral need to be set up with payee services?):

_____

_____

_____

Basic Life Skills (How is the client with ADLS, and what ADLS need addressing, if any?):

_____

_____

_____

Cultural/Linguistic Barriers (Any info here is greatly appreciated!):

_____

_____

_____

Medical/Clinical (Do they have a primary care provider? List any chronic health issues):

_____

_____

_____

Personal Support System (Family, friends, community involvement…):

_____

_____

_____

Client Notes:

_____

_____

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