THRESHOLD MH SUPPORTED LIVING REFERRAL FORM

Forms should be sent to SAM, Inc Provider Relations at: SAMBerksAdmin@sam-inc.org who will approve the referral and forward to Threshold.

Referring Provider Agency:	
Referring Provider Staff Name:	
Phone & Email Address:	

Name:	**DOB:**
Home Address:	
Phone:	**Alt Phone:**

Eligibility Criteria: The individual being referred must be at least18 years of age and meet diagnostic criteria, treatment history and functioning level as outlined in OMHSAS Bulletin 19-03 in order to be accepted into the Supported Living Program. List all current diagnosis below.

Current Treatment Agency and Provider:

MH Supported Living Services are provided in the following areas. Please indicate which areas the individual has identified as current needs:

____Securing Housing ____Using Community Resources ____Developing Independent Living Skills

____Medication Management ____Financial Planning ____Budgeting ____Service Linkages & Coordination

Reason for Referral (How will Supported Living Services benefit the individual?**)**