Young Adults in Transition Residential Treatment Home
Application Form

Young Adults in Transition (YAT) Residential Treatment Homes (RTH) are for young adults (17.5 to 25 years old) who experience complex behavioral health challenges.

YAT RTHs provide 24-hour supervision and support focusing on helping residents develop the skills needed to manage their mental health symptoms and transition into adulthood.

Services and supports include, but are not limited to:

- Therapy and medication management
- Case Management to connect to additional services as needed (i.e. supported employment, etc.)
- Skill development focusing on:
  - Self-managing emotions and mental health symptoms
  - Nutrition, personal hygiene, clothing care and grooming
  - Managing physical or health problems as needed
  - Money and household management
- Communication skills for social, health care, community resources
- Recreational and social activities

Application Process:

Referral application form (please complete all pages) and supporting clinical documentation is sent to the following contacts ***(send to all contacts listed for the program)*** for each specific home the applicant has interest in:

City	YAT RTH Name	Operated by:	Referral Contact(s):
Albany	Sender House	Trillium Family Services	Rafael Larios – rlarios@trilliumfamily.org Chi Blatt – cblatt@trilliumfamily.org
Eugene	Tempo	Kairos	Lisa Ambrose – lambrose@kairosnw.org
Grants Pass	Momentum	Kairos	Lisa Ambrose – lambrose@kairosnw.org
Pendleton	New Roads	Community Counseling Solutions	Bob McConnell -robert.mcconnell@ccsemail.org Heather Smidt – heather.smidt@ccsemail.org Da'janee Challis – dajanee.challis@ccsemail.org
Portland	Firefly	Cascadia Behavioral Health	Jaclyn Najera – jaclyn.najera@cascadiahealth.org Darcy Roseland - darcy.roseland@cascadiahealth.org Hilary Demary-- Hillary.l.demary@multco.us
Salem	Cadenza	Kairos	Lisa Ambrose – lambrose@kairosnw.org
Tigard	Zenith House	Lifeworks NW	Whitney Kosters – whitney.kosters@lifeworksnw.org
Medford	Sonata	Kairos	Lisa Ambrose-- lambrose@kairosnw.org

The YAT RTH program will review the referral and reach out to the contact listed in the referral for additional information or to schedule an interview/screening if they feel the applicant would be a good fit for their program.

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Checklist

Applicant's Name:

Primary Diagnosis/es:
(Please write out diagnoses)

Does the applicant have a significant history of psychiatric treatment?	
Does the applicant have an extended history of incarceration?	
Can applicant be reasonably expected to reside safely in the community?	
Does the applicant have the capacity to develop independent living skills?	
Does the applicant want to develop independent living skills?	

Funding:
What is applicant's source of funding?
SSI: $ SSDI: $
Other Source: $

If the applicant is not currently funded – what has been done to assist applicant in obtaining income?

What is applicant's source for medical coverage?

Clinical Documentation (At least 90 days of most recent/current records as available)**:**
***Referrals will not be accepted nor reviewed without accompanying clinical documentation**

☐	Physician history and physical within past 6 months
☐	List of current medications, dosages and length of time on medications
☐	Reports or other consultations
☐	Current psychosocial assessment
☐	Two weeks of current progress notes
☐	Current psychological assessment (if available)
☐	Current psychiatric assessment and 6 months care history
☐	Consent(s) for release of information

PPD Test within 12 months - Date of Test: Test Results:

Does the applicant have any medical, physical health concerns, or special dietary needs? If yes, please provide detail:

Does the applicant need "line of site" supervision? If yes, please explain:

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Applicant Information

Legal Name: **DOB**:

Preferred Name: **Sex:**

Gender Identity: **Identified Pronoun: Race/Ethnicity**

Preferred Language: **County of Responsibility**:

Do you currently receive SSI/SSDI? **Amount Monthly**:

Other Financial Resources:

Does someone manage your money? **Do you have a legal guardian**?

Please list name(s) and contact information for conservator/payee/legal guardian (if applicable):

Are you OHP Eligible? **DSO/Prime (Medicaid) #**:

Primary Insurance: **Secondary Insurance**:

What is your current Location (i.e. Oregon State Hospital, Respite, Secure Adolescent Inpatient Program (SAIP), shelter, etc.)?

What was your housing situation prior to current placement?

Do you have picture ID? **Social Security Card**? **Birth Certificate**?

Do you have any accommodations that may be needed (i.e. physical/environmental modifications, language, learning style, etc.)?

Do you have a child and family support team or are there people you would like to identify to provide support and encouragement to you during your transition and treatment? Please identify them and provide contact information:

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Applicant Portion

Please answer the following questions to the best of your ability. These questions will be used to help ensure that the program is a good fit and able to support your specific needs.

What would you like to accomplish during the next 6-12 months?

What are your strengths and interests?

Do you have a diploma or GED?

Are you interested in attending college, completing high school education or receiving vocational training?

Do you have any volunteer or work experience? If yes, please describe:

Are you interested in working as a volunteer to gain work experience? If so, what types of volunteer work are you interested in? C

Do you have any cultural or spiritual preferences or needs? If yes, please describe (i.e. specific holidays or traditions, religious practices, etc.):

Do you have a history of self-injurious, suicidal, or assaultive behavior? If yes, please provide details including dates:

Have you ever been charged with a crime? If yes, please provide detail including nature of charges and dates. (Please provide name and phone number of probation officer, if applicable):

Do you have a history of substance misuse and/or dependence? If yes, please provide details including dates (please include both illicit drug use and legal substances including alcohol, cigarettes, vaping, etc.):

Do you have a history of community-based mental health treatment? Please list services/dates:

What modalities/interventions do you feel have been helpful and what has not worked?

If you are accepted into a Young Adult in Transition Residential Treatment Home, how long do you plan on staying?

Where would you like to live when you move from the Residential Treatment Home?

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Applicant: **Date:**

Transition Needs: Please check all areas where you may need assistance or would like to learn more skills.

	Assistance	Learn Skill	No Need
Personal Care			
Grooming	☐	☐	☐
Laundry	☐	☐	☐
Basic First Aid and Safety	☐	☐	☐
Exercise Plan	☐	☐	☐
Symptom Management			
Medication Management	☐	☐	☐
Emotion Regulation Skills	☐	☐	☐
Self Harm	☐	☐	☐
Suicidality	☐	☐	☐
Alcohol and Drug Education support	☐	☐	☐
Relapse Prevention	☐	☐	☐
Interpersonal Skills			
Building friendships/Relationships	☐	☐	☐
Healthy Boundaries	☐	☐	☐
Internet/phone safety	☐	☐	☐
Nutrition			
Meal Planning	☐	☐	☐
Grocery Shopping	☐	☐	☐
Food Preparation/Cooking	☐	☐	☐
Community skills			
Utilizing public transportation	☐	☐	☐
Locating Service Provider Agencies	☐	☐	☐
Scheduling Appointments	☐	☐	☐
Socialization/Activities	☐	☐	☐
Driver's license	☐	☐	☐
Education/Employment			
School Support (GED, Diploma)	☐	☐	☐
Vocational Skills	☐	☐	☐
Filling out forms/applications	☐	☐	☐
Money Management			
Budgeting	☐	☐	☐
Paying Bills	☐	☐	☐
Managing checking account	☐	☐	☐
Other			
	☐	☐	☐

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Please use space below to tell us why you would like to be considered for a Young Adult in Transition Residential Treatment Home. Please describe any service needs not already listed. Include information about what things you think might be hard for you and how you think others can be most helpful to you.

I am applying for the opportunity to live in a Young Adult in Transition group home. I understand I will have to follow the rules of the home and actively work toward becoming an independent and productive adult in order to remain in the home if I am accepted. I authorize the agencies involved in this decision to contact my identified "support team" members for the purpose of getting their recommendations and to assist us in developing a care plan with me.

Applicant Signature: **Date:**

Agency/Provider Portion (to be completed by someone who knows the person well such as therapist, DHS caseworker, wrap facilitator, Probation Officer, etc.).

What do you feel the applicant would like to accomplish during the next 6-12 months?

What do you feel are the applicant's strengths and interests?

Does the applicant have a history of self-injurious, suicidal, or assaultive behavior? If yes, please provide details including dates:

Does the applicant have a history of or current legal charges? If yes, please provide details including nature of charges and dates (please include contact information if currently under legal supervision):

Does the applicant have a history of substance misuse and/or dependence? If yes, please provide details (please include both illicit drug use and legal substances including alcohol, cigarettes, vaping, etc.):

Does the applicant have a history of community-based mental health treatment? If yes, what modalities have best met the applicants needs and what has not worked?

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Applicant: **Date:**

Transition Needs: Please check all areas where applicant may need assistance or may need to learn more skills.

	Assistance	Learn Skill	No Need
Personal Care			
Grooming	☐	☐	☐
Laundry	☐	☐	☐
Basic First Aid and Safety	☐	☐	☐
Exercise Plan	☐	☐	☐
Symptom Management			
Medication Management	☐	☐	☐
Emotion Regulation Skills	☐	☐	☐
Self Harm	☐	☐	☐
Suicidality	☐	☐	☐
Alcohol and Drug Education support	☐	☐	☐
Relapse Prevention	☐	☐	☐
Interpersonal Skills			
Building friendships/Relationships	☐	☐	☐
Healthy Boundaries	☐	☐	☐
Internet/phone safety	☐	☐	☐
Nutrition			
Meal Planning	☐	☐	☐
Grocery Shopping	☐	☐	☐
Food Preparation/Cooking	☐	☐	☐
Community skills			
Utilizing public transportation	☐	☐	☐
Locating Service Provider Agencies	☐	☐	☐
Scheduling Appointments	☐	☐	☐
Socialization/Activities	☐	☐	☐
Driver's license	☐	☐	☐
Education/Employment			
School Support (GED, Diploma)	☐	☐	☐
Vocational Skills	☐	☐	☐
Filling out forms/applications	☐	☐	☐
Money Management			
Budgeting	☐	☐	☐
Paying Bills	☐	☐	☐
Managing checking account	☐	☐	☐
Other			
	☐	☐	☐

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Please use space below to tell us why you would like the applicant to be considered for a Young Adult in Transition Residential Treatment Home. Please describe any service needs not already listed. Include information about past approaches that have been successful around applicants needs or concerns the team has regarding discharge planning:

Contact Person: **Date Referred:**

Agency/Relationship: **Phone #:**

Email: