

Other formats and languages

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact Child and Family Behavioral Health at kids.team@odhsoha.oregon.gov or 971-388-2582 (voice/text). We accept all relay calls.

Young Adults in Transition Residential Treatment Home Application

Young Adults in Transition (YAT) Residential Treatment Homes (RTH) are for young adults (17 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 documentation is sent to the following contacts (send to all contacts listed for the program) for each specific home the applicant has interest in.

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.

YAT referral contacts by city

Albany

Juniper House, operated by Trillium Family Services

- Rafael Larios – rlarios@trilliumfamily.org
- Chi Blatt – cblatt@trilliumfamily.org

Sender House, operated by Trillium Family Services

- Rafael Larios – rlarios@trilliumfamily.org
- Chi Blatt – cblatt@trilliumfamily.org

Eugene

Restwell, operated by LiveGrowShare

- Ashley Teeters -- ashleyteeters@livegrowshare.org

Tempo, operated by Kairos

- Lisa Ambrose – lambrose@kairosnw.org

Grants Pass

Momentum, operated by Kairos

- Lisa Ambrose – lambrose@kairosnw.org

Medford

Sonata, operated by Kairos

- Lisa Ambrose – lambrose@kairosnw.org

Portland

Firefly, operated by Cascadia Behavioral Health

- Jaclyn Najera – jaclyn.najera@cascadiahealth.org
- Darcy Roseland - darcy.roseland@cascadiahealth.org

- Hilary Demary-- Hilary.l.demary@multco.us

Salem

Cadenza, operated by Kairos

- Lisa Ambrose – lambrose@kairosnw.org

Tigard

Zenith House, operated by Lifeworks NW

- Whitney Kusters – whitney.kusters@lifeworksnw.org

Checklist

Applicant's name:

Primary diagnosis(es) (please write out):

Does the applicant have a significant history of psychiatric treatment?

Yes No

Does the applicant have an extended history of incarceration?

Yes No

Can applicant be reasonably expected to reside safely in the community?

Yes No

Does the applicant have the capacity to develop independent living skills?

Yes No

Does the applicant want to develop independent living skills?

Yes No

Funding

What is the 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 the applicant's source for medical coverage?

Clinical documentation

Include at least 90 days of most recent/current records as available. Referrals will not be accepted or reviewed without accompanying clinical documentation.

- ☐ Physician history and physical within past 6 months
- ☐ List of current medications, dosages, and length of time on medication
- ☐ 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:

- ☐ Positive
- ☐ Negative

Date of test:

Does the applicant have any medical, physical health concerns, or special dietary needs? Please provide detail.

Does the applicant need “line of sight” supervision? Please explain.

Applicant information

Legal name:

Preferred name:

Date of birth:

Identified pronoun:

Sex:

Gender identity:

Race/ethnicity:

Preferred language:

County of responsibility:

Do you currently receive SSI? SSDI? ☐ Yes ☐ No

Amount monthly:

Other financial resources:

Does someone manage your money? ☐ Yes ☐ No

Do you have a legal guardian? ☐ Yes ☐ No

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

Are you OHP eligible? ☐ Yes ☐ No

DSO/Prime (Medicaid) # ☐ Yes ☐ No

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 a:

☐ Picture ID ☐ Social security card ☐ Birth certificate

Do you have any accommodations that may be needed? (i.e. physical 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.

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?

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 details including the nature of the charges and dates.
Please provide the 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 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?

Transition needs (applicant portion)

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

Personal care

Grooming ☐ Assistance ☐ Learn skill ☐ No need

Laundry ☐ Assistance ☐ Learn skill ☐ No need

Basic first aid/safety ☐ Assistance ☐ Learn skill ☐ No need

Exercise plan ☐ Assistance ☐ Learn skill ☐ No need

Symptom management

Medication management ☐ Assistance ☐ Learn skill ☐ No need

Emotion regulation skills ☐ Assistance ☐ Learn skill ☐ No need

Self-harm or suicidality ☐ Assistance ☐ Learn skill ☐ No need

Alcohol/drug education ☐ Assistance ☐ Learn skill ☐ No need

Relapse prevention ☐ Assistance ☐ Learn skill ☐ No need

Interpersonal skills

Building relationships ☐ Assistance ☐ Learn skill ☐ No need

Healthy boundaries ☐ Assistance ☐ Learn skill ☐ No need

Internet/phone safety ☐ Assistance ☐ Learn skill ☐ No need

Nutrition

Meal planning ☐ Assistance ☐ Learn skill ☐ No need

Grocery shopping ☐ Assistance ☐ Learn skill ☐ No need

Food preparation/cooking ☐ Assistance ☐ Learn skill ☐ No need

Community skills

Public transportation ☐ Assistance ☐ Learn skill ☐ No need

Finding provider agencies ☐ Assistance ☐ Learn skill ☐ No need

Making appointments ☐ Assistance ☐ Learn skill ☐ No need

Socialization/activities ☐ Assistance ☐ Learn skill ☐ No need

Driver's license ☐ Assistance ☐ Learn skill ☐ No need

Education/employment

School support ☐ Assistance ☐ Learn skill ☐ No need

Vocational skills ☐ Assistance ☐ Learn skill ☐ No need

Filling out forms ☐ Assistance ☐ Learn skill ☐ No need

Money management

Budgeting ☐ Assistance ☐ Learn skill ☐ No need

Paying bills ☐ Assistance ☐ Learn skill ☐ No need

Managing accounts ☐ Assistance ☐ Learn skill ☐ No need

Other

☐ Assistance ☐ Learn skill ☐ No need

Please use the space below to tell us why you would like to be considered for the Young Adult in Transition Residential Treatment Home.

Please describe any service needs not already listed. Include information about what thing 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 the 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 case worker, 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 current legal charges?

If yes, please provide details including the 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 including dates. 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 applicant's needs and what has not worked?

Transition needs (provider portion)

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

Personal care

Grooming ☐ Assistance ☐ Learn skill ☐ No need

Laundry ☐ Assistance ☐ Learn skill ☐ No need

Basic first aid/safety ☐ Assistance ☐ Learn skill ☐ No need

Exercise plan ☐ Assistance ☐ Learn skill ☐ No need

Symptom management

Medication management ☐ Assistance ☐ Learn skill ☐ No need

Emotion regulation skills ☐ Assistance ☐ Learn skill ☐ No need

Self-harm or suicidality ☐ Assistance ☐ Learn skill ☐ No need

Alcohol/drug education ☐ Assistance ☐ Learn skill ☐ No need

Relapse prevention ☐ Assistance ☐ Learn skill ☐ No need

Interpersonal skills

Building relationships ☐ Assistance ☐ Learn skill ☐ No need

Healthy boundaries ☐ Assistance ☐ Learn skill ☐ No need

Internet/phone safety ☐ Assistance ☐ Learn skill ☐ No need

Nutrition

Meal planning ☐ Assistance ☐ Learn skill ☐ No need

Grocery shopping ☐ Assistance ☐ Learn skill ☐ No need

Food preparation/cooking ☐ Assistance ☐ Learn skill ☐ No need

Community skills

Public transportation ☐ Assistance ☐ Learn skill ☐ No need

Finding provider agencies ☐ Assistance ☐ Learn skill ☐ No need

Making appointments ☐ Assistance ☐ Learn skill ☐ No need

Socialization/activities ☐ Assistance ☐ Learn skill ☐ No need

Driver's license ☐ Assistance ☐ Learn skill ☐ No need

Education/employment

School support ☐ Assistance ☐ Learn skill ☐ No need

Vocational skills ☐ Assistance ☐ Learn skill ☐ No need

Filling out forms ☐ Assistance ☐ Learn skill ☐ No need

Money management

Budgeting ☐ Assistance ☐ Learn skill ☐ No need

Paying bills ☐ Assistance ☐ Learn skill ☐ No need

Managing accounts ☐ Assistance ☐ Learn skill ☐ No need

Other

☐ Assistance ☐ Learn skill ☐ No need

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:

Phone number:

Behavioral Health Division

Child and Family Behavioral Health
500 Summer St NE
Salem OR 97301
kids.team@odhsoha.oregon.gov
Oregon.gov/OHA/BH/Families

