EXHIBIT A

HEALTH SYSTEMS

TRANSITIONAL VOUCHER PURCHASE REQUEST

Client Data			
SSN:		County of Residence:	
Last Name:		Primary Insurance:	
First Name:		Legal Custodian's Name:	
Middle Initial:		Legal Custodian's Phone Number:	
Gender:	Male ☐ Female ☐	Legal Custodian's Address:	
Date of Birth:		Current Mental Health/Substance Abuse Provider:	

What other funding streams have been explored?	
Other services already in place? If yes, which ones? (e.g. outpatient counseling, med mgmt.)	

Total monthly income: $_____Source(s) of income: _____
Has this person applied for SSI/SSDI? ☐ Yes, Date: _____ ☐ No
Has this person been referred to a SOAR Processor? ☐ Yes, Name of SOAR Processor: _____ ☐ No
Benefits (Insurance/Food Stamps/Other Subsidies): _____

Please list all Mental Health, Substance Abuse, and Physical Health Diagnoses:

Part I – Initial Screening –Eligibility

The consumer must meet the following criteria:	**Yes**	**No**
1. A current mental health diagnosis **and/or**	☐	☐
2. A current substance abuse diagnosis **and**	☐	☐
3. Must meet at least one of the following:	☐	☐
a) Experiencing Homelessness	☐	☐
b) Receiving Care Coordination	☐	☐
c) Participating in FACT Teams	☐	☐
4. A Housing Checklist has been completed for Housing Subsidy requests	☐	☐ N/A ☐

**LSFHS will review the referral and determine if it meets all eligibility criteria*

Part II – Service Requested

Type of Service (choose **only** one):
- Housing Subsidy ☐
- Child Care ☐
- Vocational Services ☐
- Pharmaceuticals ☐
- Time-Limited Transportation ☐
- Housing Assistance ☐
- Clothing ☐
- Educational Services ☐
- Medical Care ☐
- Other ☐

If requesting ALF or group home funding:

Does the owner live in the facility? ☐ Yes ☐ No

How many people live in the facility (not including embers or relatives)?

Are there any residents received OSS payments? ☐ Yes ☐ No

Does the staff provide one or more personal Care Services related to residents on a 24-hour Basis (supervisor assistance with bathing, dressing, eating, toileting, hygiene, and/or medications?) ☐ Yes ☐ No

Treatment/Service Plan Goal to Address with this funding (send copy of treatment/service plan if available):

Estimated Cost of Service:	Vendor to Provide Service:
Frequency of Service (ex. daily, weekly, monthly, one-time):	Vendor Credentials (ex. W-9, professional credentials):
Start Date of Service:	Vendor Telephone Number:
End Date of Service:	Vendor Address:

Requestor Data

Form completed by:	Date:	Agency:
Address:	Telephone Number:	
Fax Number:	Email:	

This section to be completed by LSF: (ONLY for those purchases in excess of $1,000 and ALF Requests)

ALF Requests Only: **Documentation showing due diligence was exercised in searching for less restricting housing in these cases submitted to DCF?** Yes ☐ No ☐ Date of DCF Approval: Name of DCF Approver:

The requested services has been: Approved ☐ Denied ☐ Bill to (circle one): MHTRV MSTRV MSTV2 MHDRF

Comments:

_____ LSFHS Representative	_____ Date
_____ Director of Program Operations or Regional Director of SOAR and Housing Initiates	_____ Date