Referral Form - Pan-American Square Apartments
DOH/ESSHI Permanent Supported Housing

UPDATED 6/30/2025

Applicant Name: _____ Date of birth: _____ / _____ / _____

Before completing this referral, please ensure (and check off) the following:

- ☐ This individual is 18+ years old ***AND***
- ☐ This individual has a Substance Use Diagnosis (SUD) ***OR***
- ☐ This individual is Chronically Homeless (CH)

Diagnosis Codes: _____

_____

Before submitting this referral, please ensure (and check off) the following:

- ☐ Completed DOH/ESSHI Permanent Supported Housing application ***AND***
- ☐ Signed Authorization for Releases of information to obtain additional information from current or most recent treatment provider ***AND***
- ☐ Current (within 1 year of application) SUD treatment Assessment (SUD program)

Submit referral by email: **panamerican@depaul.org**

Questions? call: **716-325-8590**

DePaul's Pan-American Square Apartments:
2633 Delaware Avenue
Buffalo, NY 14216

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Referral Information

Referral is for: ☐ SUD Program ☐ CH Program Referral date: _____ / _____ / _____

Applicant name: _____

Gender Identity: ☐ Male ☐ Female ☐ Preferred pronoun: _____

Current location: _____ Phone #: _____

Mailing Address: _____

_____

Social Security #: _____ **Date of birth:** _____ / _____ / _____

Inpatient? ☐ Yes ☐ No ***If yes,*** anticipated release date: _____ / _____ / _____

Referring Agent Contact Information

Referral Agency: _____

Referred by: _____ Title: _____

Phone #: _____ Email: _____

Mailing address: _____

_____

Does this individual have a care manager or other supports? ☐ Yes ☐ No
(such as Adult protective, outreach worker, HHCM, etc.)

- ***If yes,*** Agency name: _____

Contact informtion: _____

Agency address: _____

Living Situation

Section 8 status: _____

Prior living situation: _____

_____

_____

If planning to live with family/friend, please list other members of the household:

_____

_____

_____

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Legal Status

Parole? ☐ Yes ☐ No **County Probation?** ☐ Yes ☐ No **Federal Probation?** ☐ Yes ☐ No

- ***If yes,*** PO name and phone #: _____

Detail a arrests/charges/convictions current/history:

_____

_____

_____

_____

Restrictions? ☐ Yes ☐ No - ***If yes,*** provide details below

_____

_____

_____

Current involvement with (check all that apply)**:**

☐ CPL ☐ Court Order or Diversion ☐ Town Court ☐ Treatment Court

☐ Adult Protective Services ☐ Child Protective Services

☐ Assisted Outpatient Treatment (AOT) ☐ Other: _____

Personal And Demographic Information

Race/Ethnicity

- ☐ White, Non-Hispanic
- ☐ Black, Non-Hispanic
- ☐ Hispanic
- ☐ Asian
- ☐ American Indian/ Native American
- ☐ Other (specify)

Primary Language

- ☐ English
- ☐ Spanish
- ☐ American Sign Language (ASL)
- ☐ Other: _____

English Proficiency (if English is not primary language)

- ☐ Does not speak English
- ☐ Poor
- ☐ Fair
- ☐ Good (does not need a translator)

Literacy Level: ☐ Below Basic ☐ Basic ☐ Intermediate ☐ Proficient

Marital status: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed

Children in custody:

☐ No children ☐ Minor children in client's custody ☐ Minor children, not in custody, no access

☐ Has children older than 18 years ☐ Minor children not in custody, has access

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Veteran Status

Veteran or served in the military: ☐ Yes ☐ No

- ***If yes,*** Branch/type of discharge: _____

Service connected disability: ☐ Yes ☐ No - ***If yes,*** % _____

Current Education Level

☐ No formal education
☐ Some grade school (1-8th grade)
☐ Completed grade school
☐ Some Highschool (9-12th grade, but no diploma)
☐ Master's Degree
☐ Highschool diploma or GED
☐ Vocational business training
☐ Some college (no degree)
☐ College Degree
☐ Other: _____

Income Sources (include amounts)

☐ SSI $_____
☐ SSDI $_____
☐ TANF $_____
☐ Employment Wages $_____
☐ Child Support $_____
☐ None $_____
☐ Temporary Assistance $_____
☐ Food Stamps/SNAP $_____
☐ Veteran's Benefits $_____
☐ Family/Spouse Support $_____
☐ Pension $_____
☐ Other income: $_____

Representative Payee

Current payee? ☐ Yes ☐ No - ***If no***, is one recommended? ☐ Yes ☐ No

- ***If yes,*** Payee name/agency: _____ Phone # _____

Address: _____

Insurance Information

Client Medicaid (CTN)# _____ HARP Eligible? ☐ Yes ☐ No ☐ Unknown

Managed Care Company: _____ Other Insurance: _____

Medicaid Active? ☐ Yes ☐ No Name: _____

Medicare Active? ☐ Yes ☐ No Policy # _____

Hospitalizations

Number of ER visits for psychiatric or SUD reasons in the last 12 Months: _____

Number of inpatient hospitalizations in the last 24 Months: _____ Length of Stay: _____

Dates: _____ Hospital: _____

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SUD Information **Drug(s) of choice** (check all that apply)

- ☐ None
- ☐ Alcohol
- ☐ Amphetamines
- ☐ Any IV drug use
- ☐ Benzodiazepines
- ☐ Crack
- ☐ Cocaine
- ☐ Fentanyl
- ☐ Hallucinogens
- ☐ Heroin/Opiates
- ☐ Inhalants (glue/other household products)
- ☐ Marijuana/Cannabis
- ☐ PCP
- ☐ Prescription drugs
- ☐ Sedative/Hypnotic
- ☐ Spike (Synthetic Marijuana)
- ☐ Xylazine
- ☐ Other: _____ Date of last use: _____ / _____ / _____

History of in-patient/outpatient SUD Treatment: Yes No

- ***If yes,*** where: _____

when: _____

Clinical Information **Diagnosis** **Code**

- ☐ DSM 5 MH _____ _____
- ☐ DSM 5 SUD _____ _____
- ☐ Developmental Disorder _____ _____
- ☐ Chronic health Conditions _____ _____
- ☐ Other health Conditions _____ _____
- ☐ Cognitive Disorder _____ _____
- ☐ Learning Disability _____ _____

Clinician name: _____ Phone # _____

Psychiatrist name: _____ Phone # _____

SUD Provider name: _____ Phone # _____

Physical Health/Wellness **Check all that apply:**

- ☐ Asthma
- ☐ Breathing or Lung Problems
- ☐ Chronic Pain
- ☐ Diabetes
- ☐ Hearing impairment
- ☐ Heart Problems
- ☐ Incontinence
- ☐ Impaired Walking
- ☐ Traumatic Brain Injury
- ☐ Impaired Vision/Blind
- ☐ High Blood Pressure
- ☐ Other: _____

Requires special medical equipment: _____

History

Yes	No		Date of most recent episode
☐	☐	AOT Order	_____ / ____ / _____
☐	☐	Arson or fire starting	_____ / ____ / _____
☐	☐	Current Access to Firearms	_____ / ____ / _____
☐	☐	Destruction of Property	_____ / ____ / _____
☐	☐	History of Domestic Violence in Home	_____ / ____ / _____
☐	☐	History of Homelessness	_____ / ____ / _____
☐	☐	History of Suicidal Ideation	_____ / ____ / _____
☐	☐	History of Suicide Attempts/Self Harm	_____ / ____ / _____
		Please Elaborate: _____	
☐	☐	Physically Abusive and/or Assaultive of Another	_____ / ____ / _____
☐	☐	Self-Harm/Self-Mutilation	_____ / ____ / _____
☐	☐	Sexually Assaultive or offensive Behavior	_____ / ____ / _____
☐	☐	Victim of Physical/Sexual Abuse	_____ / ____ / _____

Reason for Referral

Please include all relevant information for referral, longest history of sobriety, triggers, sober supports, Current symptoms, desired outcome, if there is a significant change from a previous referral, etc.

Signature of Applicant: _____ Date: ____ / ____ / _____
SIGNATURE REQUIRED

Print name: _____