

Participant Name: _____ Date: _____

Diagnosis <i>Please check off all the applies</i>	Service Needs One or more of the following
The individual must have one of the following diagnosis:	_____ Two or more acute psychiatric hospitalizations and/or 4 or more Emergency room visits in the last 6 months
_____ Schizophrenia	_____ Persistent and severe symptoms of a psychiatric disability that interferes with the ability to function in daily life
_____ Other Psychotic Disorders; describe:	Must have one of the following:
_____ Bipolar Disorder	_____ Inability to participate or remain engaged or respond to traditional community based services
_____ Major Depressive Disorder	_____ Inability to meet basic survival needs or residing in substandard housing, homeless, or at imminent risk of becoming homeless
These may also be accompanied by any of the following either:	Must have three of the following:
_____ Substance Use Disorder	_____ Evidence of a co-existing mental illness and substance abuse / dependence
_____ Developmental Disability	_____ Significant suicidal ideation with a plan and ability to carry out within the last two years
Additional Notes:	_____ Suicide attempt in the last two years
	_____ History of violence due to untreated mental illness / substance abuse within the last two years
	_____ Lack of support systems
	_____ History of inadequate follow-through with
	_____ Threats of harm to others in the past two years
	_____ History of significant psychotic symptomology such as command hallucinations to harm others

Licensed Mental Health Professional/ Print Name

Signature

Date