HomeBASE
ADAPTIVE CASE MANAGEMENT

HOMEBASE ADAPTIVE CASE MANAGEMENT (ACM) REFERRAL PACKAGE

To be completed in full by the Referral Source (ICA Tier 3 System Navigator) and submitted to CasePlacement@gmail.com. Incomplete referrals will not be accepted

Program Description

HomeBASE ACM works with individuals who are living in homelessness, at risk of becoming homeless and/or have complex needs that would impact their housing stability.

These services include support for finding and maintaining housing such as:

- Case Management Support
  - Development and ongoing support of individualized service plans for independent living
  - Enhancing life skills
  - Addressing physical and mental health needs
  - Identifying meaningful daily activities
- Advocacy with landlords, income sources and connections to other service providers

CMHA HomeBASE ACM and other CMHA programs do **NOT** have the ability to provide funding and/or access to immediate housing.

ELIGIBILITY CRITERIA			
Is the client living or relocating to the city of Lethbridge *(is able to travel into Lethbridge)*? *(Program Service Area: Lethbridge, Coaldale & Coalhurst)*			☐ Yes ☐ No
Is the client able to independently maintain market housing? **If clients have been assessed for designated supportive living – this would not be an appropriate program**			☐ Yes ☐ No
Does at least one of these situations apply? *Check off all that apply* ☐ Living in homelessness or at risk of becoming homeless ☐ Eviction (doesn't meet the criteria of LHA Eviction Prevention program) ☐ Complex needs impacting their housing stability			☐ Yes ☐ No
Does the client want to participate in wrap around supports? *A hands-on approach to achieving goals and meeting client needs to maintaining housing and increase wellbeing*			☐ Yes ☐ No
Does the client agree to engage in case management supports such as: • Working collaboratively on goals • Frequent check-ins: home visits (up to 5 times/week), phone, email • This support can occur over 5 years			☐ Yes ☐ No
Does the client's SPDAT score fall within the identified range? *(Complete the relevant SPDAT line)*	*Single or Youth SPDAT*	*Rapid Re-Housing: 20-34* *ACM: 35-60*	☐ Yes ☐ No
	Family SPDAT	*Rapid Re-Housing: 27-53* *ACM: 54-80*	☐ Yes ☐ No

If any of the answers are NO, this may not be an appropriate referral
If the client's situation meets the eligibility criteria, please complete the following referral information

HomeBASE
ADAPTIVE CASE MANAGEMENT

Has the client been informed of the HomeBASE ACM program prior to the referral? ☐ Yes ☐ No
Reason for Referral – Please provide a short description of what is prompting the referral

CLIENT INFORMATION		
First Name:	Last Name:	
Name listed on Government issued ID *(if different from above)*		
Does the client have a Government issued ID? ☐ Yes ☐ No		
DOB (MM/DD/YYYY):	Age:	# of Dependents:
Best Contact Phone Number:		
Does the client have a Guardian? ☐ Yes ☐ No If yes, who:		
While not guaranteed, please specify Case Manager gender preference, if applicable:		

SPDAT ***the summary must be attached to the referral**	
Current SPDAT Score:	Is the SPDAT Summary Attached? ☐ Yes ☐ No

HEALTH INFORMATION

Alberta Health Care Card ☐ Yes ☐ No

Diagnosed or Suspected physical and/or mental health conditions ☐ Yes ☐ No

If yes, please describe

Family Physician ☐ Yes ☐ No If yes, who:

Psychiatrist ☐ Yes ☐ No If yes, who:

Mental Health Therapist ☐ Yes ☐ No If yes, who:

Please list any other health related service providers the client is connected to:

Does the client experience any physical mobility issues that would impact housing options?

☐ Yes ☐ No

If yes, please describe

HomeBASE
ADAPTIVE CASE MANAGEMENT

SAFETY INFORMATION	
History of harm to others *If yes, please describe*	☐ Yes ☐ No
History of harm or aggression towards staff *If yes, please describe*	☐ Yes ☐ No
History of harm from others *If yes, please describe*	☐ Yes ☐ No

FINANCIAL INFORMATION			
Bank Account	☐ Yes ☐ No	Available finances for rent (currently)	☐ Yes ☐ No
Trusteeship *If yes, who:*	☐ Yes ☐ No		
Income Source *If yes, from where:*	☐ Yes ☐ No		

ADDITIONAL SUPPORTS	
Is the client connected to other professional supports? *If yes, who:*	☐ Yes ☐ No
Is the client connected to family or other natural supports *If yes, who:*	☐ Yes ☐ No

Date of Referral (MM/DD/YYYY): _____

Referring Service Provider Organization: _____

Referring Service Provider Name: _____

Phone Number: _____

Email: _____

Service Provider Signature: _____