|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  HOME AND COMMUNITY SERVICES (HCS)  GOVERNOR’S OPPORTUNITY FOR SUPPORTIVE HOUSING (GOSH)  **GOSH Referral**  Initial  Transfer | | | | | | | | |  |
| DATE |
| HCS / AAA Case Manager (CM) to send completely filled-out Referral form, with all documents attached, to [Regional GOSH PM](https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/RCL/ALTSA%20Housing%20Regional%20Map.pdf). ALTSA’s GOSH service supports in-home transitions for those discharging / diverting from Eastern or Western State Hospital by connecting them with a Supportive Housing Provider (SHP). The SHP works to assist a client secure independent housing and maintain that housing ongoing through targeted tenancy support.  Please see [Chapter 5b of the Long-Term Care Manual](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%205b.docx) for more information regarding ALTSA’s GOSH service. | | | | | | | | | | |
| CLIENT’S NAME | | | | | CLIENT’S PREFERRED NAME | | PREFERRED PRONOUN | | | DATE OF BIRTH |
| ACES NUMBER | | PROVIDERONE NUMBER | | | SSN | | REFERRING CM | | | |
| What city / county does the client want to live in? Include secondary location, if one. | | | | | | | | | | |
| PREFERRED | | | | SECONDARY / ADDITIONAL | | | | Has an apartment; if checked:  LOCATION OF APARTMENT | | |
| ADDITIONAL INFORMATION FOR PROVIDER ASSIGNMENT CONSIDERATION  What should the SHP know? Language, gender, or cultural preferences? Please note if the client has criminal background (if yes, is it captured in CARE)? | | | | | | | | | | |
| **Referral Type** | | | | | | | | | | |
| Discharge:  ESH  WSH  Psychosocial Assessment and Ward Social Worker notes attached  Diversion / Facility:  Judge / Commissioner – signed court commitment paperwork attached  Signed DSHS Consent form attached  Assessment Detail attached  Service Summary attached | | | | | | | | | | |
| **Eligibility** | | | | | | | | | | |
| Functional  Financial | | | | | | | | | | |
| FINANCIAL ELIGIBILITY NOTES (IS CLIENT OVER-RESOURCED? IF YES, WHAT IS THE SPENDDOWN PLAN? ETC.) | | | | | | | | | | |
| **Client Currently has:** | | | | | | | | | | |
| Social Security card  Current ID  Birth certificate | | | | | | | | | | |
| **Level of Behavioral Health Services client is / will be referred:** | | | | | | | | | | |
| PACT  Intensive Outpatient  Other (specify): | | | | | | | | | | |
| **Is there a discharge plan?** | | | | | | | | | | |
| Yes  No | | | | | | | | | | |
| DISCHARGE NOTES (INCLUDE DATE / TIMELINE, LOCATION, ETC.) | | | | | | | | | | |
| **Client Team (to be completed by assigned HCS / AAA case manager)** | | | | | | | | | | |
| TYPE | | | NAME | | | EMAIL | | | PHONE | |
| HCS / AAA CM | | |  | | |  | | |  | |
| HCS / AAA Supervisor | | |  | | |  | | |  | |
| HCS Public Benefits Specialist | | |  | | |  | | |  | |
| Psychiatric Facility Discharge SW | | |  | | |  | | |  | |
| Ward SW (applicable to ESH / WSH) | | |  | | |  | | |  | |
| Psychiatric Facility SW Supervisor | | |  | | |  | | |  | |
| MCO / MCO Liaison | | |  | | |  | | |  | |
| Behavioral Health Provider | | |  | | |  | | |  | |
| Behavioral Health Provider Supervisor | | |  | | |  | | |  | |
| Peer Bridger | | |  | | |  | | |  | |
| Assigned DOC Contact | | |  | | |  | | |  | |
| **GOSH Program Manager completes** | | | | | | | | | | |
| TYPE | | | NAME | | | EMAIL | | | PHONE | |
| Supportive Housing Provider | | |  | | |  | | |  | |
| Supportive Housing Provider Supervisor | | |  | | |  | | |  | |
| ALTSA Supportive Housing Program Manager | | |  | | |  | | |  | |
| AAA CM | | |  | | |  | | |  | |
| AAA Supervisor | | |  | | |  | | |  | |
| ADDITIONAL NOTES | | | | | | | | | | |

|  |
| --- |
| **Governor’s Opportunity for Supportive Housing (GOSH): Referral Instructions**   1. **Purpose**   To refer an ALTSA client to GOSH. The GOSH Program Manager will confirm eligibility upon receipt of the GOSH Referral Form. If the client is eligible for GOSH, the Program Manager will process the referral. If the client is not eligible for GOSH, the Program Manager will email the referring CM and enter a SER with this information.   1. **Instructions** 2. This form is to be completed electronically by the Home and Community Services (HCS) or Area Agency on Aging (AAA) Case Manager working with the client. 3. Fill out all information and answer all applicable questions. 4. When submitting the referral, make sure to attach or send all supporting documentation, including signed DSHS Consent form, Assessment Detail, Service Summary, Psychosocial Assessment and Ward Social Worker Notes for Eastern or Western State Hospital discharges and/or Judge / Commissioner signed court commitment paperwork for community diversion referrals. 5. The GOSH Program Manager will submit eligible referrals, along with supporting documentation attached, to a GOSH Provider. Upon acceptance by a GOSH Provider, the Program Manager will fill out their section of the referral form and send out to the team. The HCS / AAA Case Manager will submit the GOSH Referral to DMS at that time. 6. For more information regarding GOSH referrals or services, see Long-Term Care Manual [Chapter 5b: Housing Resources for ALTSA Clients.](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%205b.docx) |