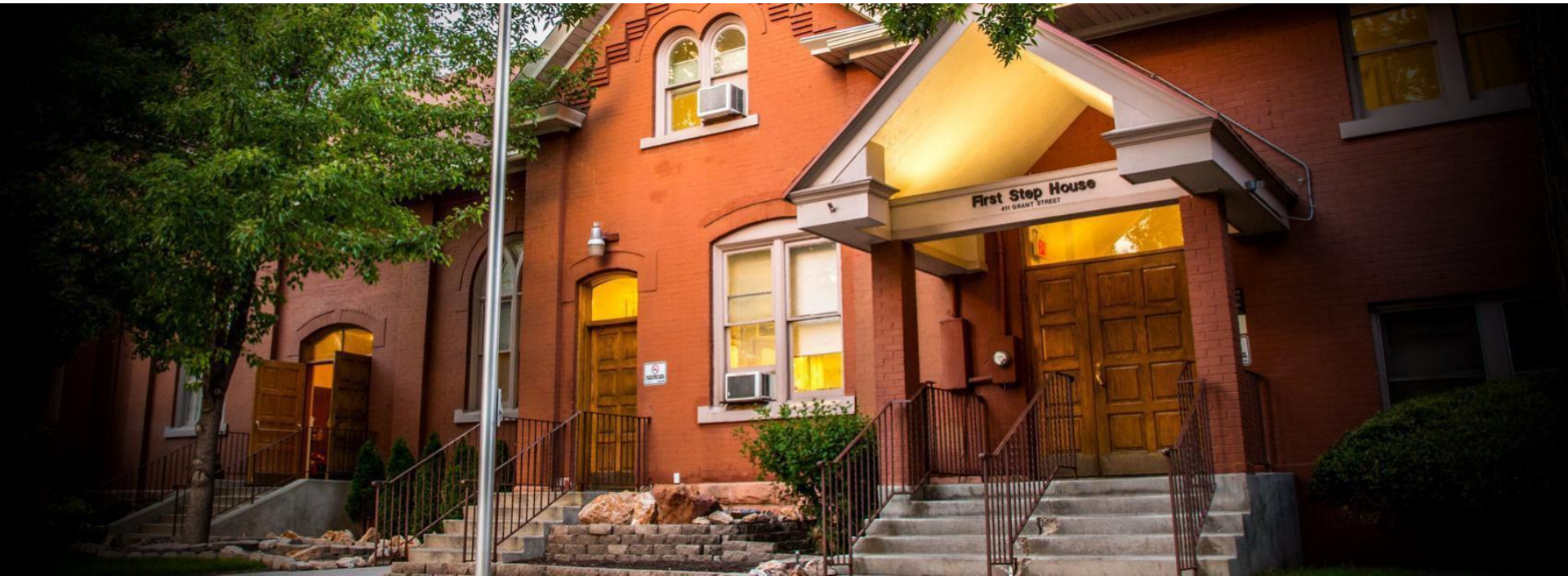
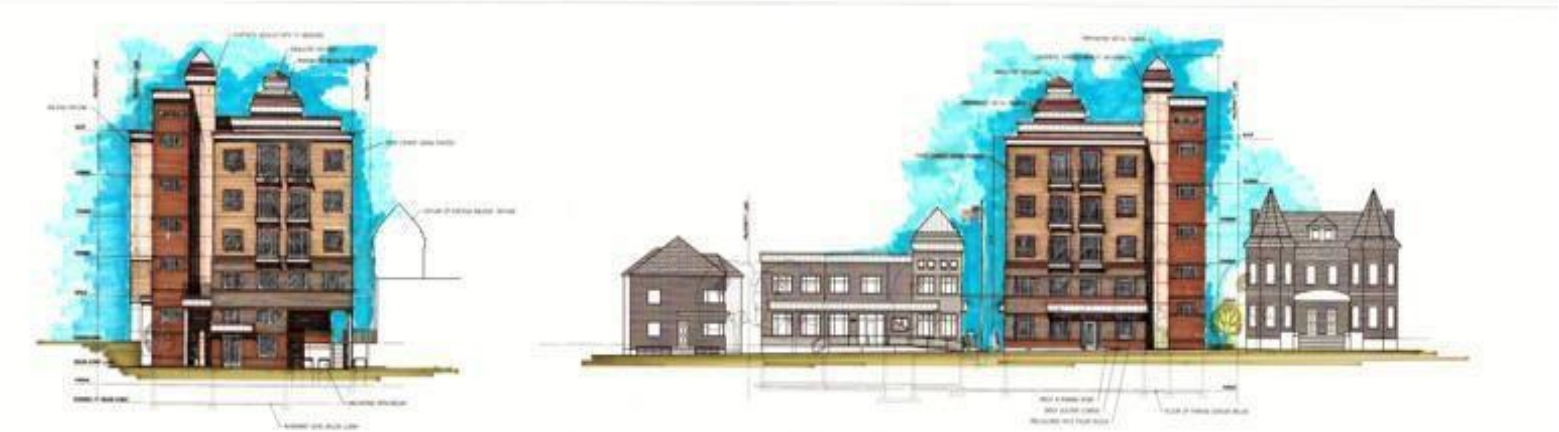
FIRST STEP HOUSE

"We help people build lives of meaning, purpose, and recovery"



Central City Apartments & CHARTER Supportive Living Services

439 Denver Street
Salt Lake City, UT 84111



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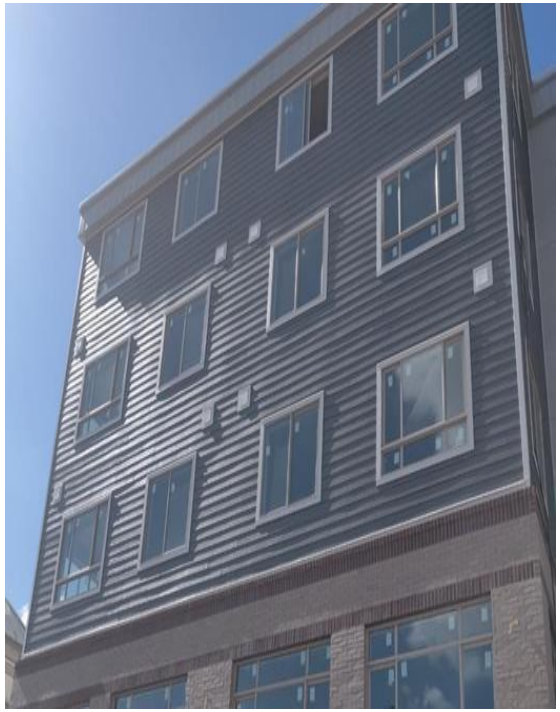
Building Overview

- Brand new building
- 5 Floors
- Building space consists of:
  - Central City Apartments (west entrance)
  - Outpatient Services (east entrance)
- 75 Units, including 9 accessible units
- 1 Bedroom & 1 Bath Units
- 540 Square Feet per Unit
- Supportive Living



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Building Overview

- Residences located on floors 3, 4 & 5
- Trauma-Informed Design
- Utilities Included
- All units furnished with:
  - Full Size Bed & Bed Frame
  - Nightstand
  - 5 Drawer Chest
  - Love Seat
  - TV & TV Stand
  - Kitchen Table and Chairs (2)
  - Stove & Refrigerator
  - Cookware/Dishware

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Building Overview

- Underground Parking
- Controlled Access
- Exercise Room
- Computer Room
- Library
- 3 Laundry Rooms
- Wellness Room
- Wireless Internet
- Community Room with Kitchen

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Target Population & Qualifications

- Single adult males and females
- Chronically homeless, homeless, or at risk for homelessness
- Individuals suffering with a Serious Mental Illness (SMI)
- Individuals with a disability or a disabling condition
  - Must have Optum Legacy Medicaid
- Individuals who meet current income guidelines of 30% or less of AMI ($19,380)
  - Individuals with no income & using a Housing Connect Voucher, or a Project-Based Voucher, will need to pay $50 monthly per HUD requirements
- High utilizers of the system – those cycling in and out of care
- A written recommendation from a physician, or a practitioner of the "healing arts" has been made for "supportive living"
  - FSH can also make this recommendation for individuals that are self-referred via an assessment

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Property Management

- Housing Connect
- 1-year lease
- Deposit = $500.00
  - FSH can help with deposit assistance
- Rent = 30% of income or $50 monthly
- Contact Info:
  - Jeff Webb, Property Manager
    - Office: 801-270-1341
    - Cell: 801-289-6233
    - Direct email: jeffwebb@housingconnect.org
    - Main email: centralcity@housingconnect.org

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What's CHARTER?

Community

Housing and

Assertive

Response for

Treatment

Enhanced

Recovery

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CHARTER Supportive Living Services

- 24-hour Support Staff
- Transportation Services
- Socialization Opportunities
- Resident Council
- On-site Recovery Meetings
- 24/7 Crisis Coordination
- Behavioral Health Care Coordination with the resident's primary provider

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Outpatient Mental Health Services
First Step House

- Individual Therapy
- Psychoeducation Groups and Classes
- Life Skills Classes
  - Independent Living Skills
  - Social Skills
- Substance Use Disorder Services
  - Groups, Classes, Individual Counseling
- Assessments
- Peer Support Services
- Medication Management
- Case Management
- Employment Services

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Referral Form

Central City Apartments/CHARTER Supportive Living Referral Form

Email completed forms to: hbenson@firststephouse.org If you have any questions, please contact Heatherlee Benson at 385-707-7323 (cell), or 801-359-8862 ext. 2121 (office), or email to the address above.	
Referring Provider Information	
Referral Agency:	
Referral Date:	
Referring Provider Name and Credentials:	
Phone:	
Email:	
Relationship to individual in need of services:	
Applicant Information	
Name:	
Phone:	
Email:	
Date of Birth:	
Gender: Preferred Pronouns:	
Current housing situation (e.g. homeless, hospital):	
Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed	
If not English-speaking, preferred language:	
Medicaid Type: ☐ Legacy ☐ Targeted Adult Medicaid (TAM) ☐ Adult Expansion (AE)	
Medicaid Number:	
Eligibility Criteria – *all five items MUST be marked "yes" to qualify - do not proceed if any boxes are marked "no"*	
1. Meets the approved definition of homelessness or near homeless – refer to 'Definitions' section of packet	☐Yes ☐No
2. Meets criteria for Serious Mental Illness (SMI), as defined by the State of Utah – refer to 'The Utah Scale on Serious Mental Illness' on page 9 for criteria - **for reference only - no signature required**	☐Yes ☐No
3. Meets the definition of being a person with disabilities or a person with a disabling condition – refer to 'Definitions' section of packet	☐Yes ☐No
4. Meets current income guidelines of 30% or less of AMI (i.e. $18,480)	☐Yes ☐No
5. A written recommendation has been, or can be provided by an approved practitioner of the healing arts for "supportive living" – see template on page 5 - **signature required**	☐Yes ☐No
Legal History – *please indicate if the applicant has been convicted of any of the following within the last 10 years*	
Arson ☐Yes ☐No If yes, please explain, including dates:	
Murder ☐Yes ☐No If yes, please explain, including dates:	
Attempted Murder ☐Yes ☐No If yes, please explain, including dates:	

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Aggravated Assault and/or Batter; Manslaughter ☐Yes ☐No If yes, please explain, including dates:
Manufacturing Methamphetamine: ☐Yes ☐No If yes, please explain, including dates:
Actively Listed on the National Sex Offender Registry: ☐Yes ☐No If yes, please explain:
Active Warrants: ☐Yes ☐No If yes, please explain:
Does the applicant pose a risk to other vulnerable individuals? ☐Yes ☐No If yes, please explain:
Additional Comments:
Clinical Information
Primary Psychiatric Diagnosis:
Secondary Psychiatric Diagnoses:
Current Symptoms:
Current Substance Use Disorder: ☐Yes ☐No If yes, please explain:
Current Suicidal/Homicidal thoughts: ☐Yes ☐No If yes, please explain:
Current Psychiatric Medications:
Prescribing Physician: Contact Info:
What support services is the individual currently engaged in (e.g. mental health, substance abuse)? Please specify:
Is the individual experiencing any problems with current support services? ☐Yes ☐No ☐Unknown If yes, please explain:
Additional Comments:
Past Psychiatric/Substance Use History (hx)
Hx of violence? ☐Yes ☐No If yes, please describe:
Hx of suicide attempts? ☐Yes ☐No If yes, how recent:
Hx of psychiatric hospitalization? ☐Yes ☐No If yes, how many, and when:
Hx of substance use disorder? ☐Yes ☐No If yes, briefly explain:
Additional Comments:
Health Information - *please indicate if the individual endorses any of the following*
Hearing Loss: ☐Yes ☐No If yes, preferred method of communication:
Vision Impairment (e.g. blind, legally blind): ☐Yes ☐No If yes, preferred method of communication:
Intellectual/Developmental Disability: ☐Yes ☐No ☐Unknown If yes, please explain:

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Brain Injury (i.e. stroke, head injury): ☒Yes ☐No ☐Unknown
If yes, please explain:

Memory Loss: ☒Yes ☐No ☒Unknown
If yes, please explain:

Diabetes: ☒Yes ☐No ☐Unknown
If yes, please explain:

Heart Problems or Surgery: ☐Yes ☐No ☒Unknown
If yes, please explain:

Pulmonary (lung) Problems: ☐Yes ☐No ☒Unknown
If yes, please explain:

Current Smoker: ☒Yes ☐No ☐Unknown
If yes, please explain:

Physical Disability: ☒Yes ☐No ☐Unknown **ADA Room:** ☒Yes ☐No ☐Unknown
If yes, please explain:

Any other current health conditions:

Additional Comments:

Does the individual have any of the following?

Legal Guardian: ☐Yes ☒No ☐Unknown
If yes, who:

Payee: ☐Yes ☐No ☐Unknown
If yes, who:

Advanced Directives: ☒Yes ☐No ☒Unknown
If yes, who:

Additional Comments:

Recommended Services – *please indicate which services the applicant would benefit from*

General Supportive	Independent Skills	Health & Medical	Mental Health
☐ Crisis intervention	☐ Communication skills	☐ Health & wellness edu.	☐ Medication Evaluation
☐ Peer mentoring	☐ Conflict resolution skills	☐ Med mgmt/monitoring	☐ Psychosocial assessment
☐ Case management	☐ Benefits counseling	☐ Pain management	☐ Individual Therapy
☐ Transportation	☐ Money management	☐ Personal care/hygiene	☐ Support groups
☐ Social/rec opportunities	☐ Housekeeping training	☐ Home health services	☐ Group therapy
☐ Food assistance (e.g. food bank	☐ Cooking/meal prep. training	☐ Routine medical care coordination	☐ Mental health education

Substance Abuse	Employment	Other, please specify
☐ MAT coordination	☐ Job skills training	
☐ SA counseling	☐ Job preparation skills	
☐ Relapse prevention	☐ Job retention services	
☐ Sober support groups	☐ Job placement/develop.	
☐ Peer-to-peer groups	☐ Volunteer opportunities	
☐ Sober recreation	☐ Adult Education	

First Step House

Consent for Disclosure of Confidential Information

I, _____, ____/____/_____,
(Full Legal Name) (Date of Birth)

hereby consent to the exchange of written and verbal information between First Step House to the following parties:

- ☑ **Housing Authority of Salt Lake City (HASLC),** designee
- ☑ **Housing Connect**, designee
- ☑ **Salt Lake County Division of Behavioral Health Services**, designee
- ☑ **United Behavioral Health/Optum,** designee

Information to be disclosed: Application information including: eligibility criteria, legal history, clinical information (e.g. diagnosis', recommendations, substance abuse history), medication history – past and present, health history – past and present, recommended services

The purpose of this disclosure is: Coordination of services

I understand that in order to protect the confidentiality of my records, my consent to obtain or release information is necessary, and that this consent is limited to the parties and purposes listed above. I have been informed that there are exceptional circumstances under which First Step House may be required to disclose information without my consent: *in the event I am considered a danger to myself or others; in the event of a medical emergency; to protect public health; in response to a court order prepared in accordance with Subpart E of the Federal confidentiality regulations (42 C.F.R. § 2.13).*

I understand that First Step House may not deny me treatment based on whether or not I give consent for communication with the parties listed above. However, if my treatment is mandated by the criminal justice system, refusal to give consent places me in non-compliance with the legal conditions established, and I may be subject to sanctions including reinstatement of original charges and sentencing. I also understand that if my treatment is mandated by the criminal justice system, *I may not revoke this consent*, but it cannot remain in effect beyond the final disposition of the legal proceedings which resulted in my referral to treatment. Otherwise, I may revoke this consent at any time.

I understand that any disclosures made are protected by Federal Regulations C.F.R. 42 part 2 governing confidentiality of patient records, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 & 164. 42 C.F.R. Part 2, Section 2.35 allows the parties listed above to re-disclose this information if necessary as part of their official duties. This consent will be effective from this date until (select one):

- ☑ 180 days following discharge
- ☐ Other event or condition, *please specify:*

_____ _____
Client Signature ***Date***

_____ _____
Staff Signature ***Date***

_____
Staff Witness (print)

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Practitioner Recommendation for Supportive Living

Please use this form as an option to communicate a recommendation for supportive living. If the practitioner does not wish to use this form, another form of clinical documentation will need to be provided specifically recommending "supportive living" for the referred individual. Providers with the following credentials are qualified to prescribe this service: LCSW, CMHC, MFT, CSW, ACMHC, AMFT, APRN, MD

Agency:

Practitioner Name and Credentials:

Phone: ☐Work ☐Cell

Email:

To Whom it May Concern,

It is my clinical recommendation that _____ would benefit from supportive living services, as evidenced by:

Please select one of the options below:

- ☐ I am currently treating this patient
- ☐ I have treated this patient within the last 6 months

_____ _____

Signature & Credentials of Practitioner **Date**

This document is part of the Services Referral Packet for Central City Apartments/CHARTER Supportive Services. Please include this document with initial Services Referral request. If the individual is self-referred, FSH can make the recommendation for supportive living, if indicated, following an assessment.

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TENANT INQUIRY RELEASE

I, the under-signed certify that the information given is accurate. I give my authorization to The Housing Authority of the County of Salt Lake and Back Track Screening to verify any and all information below, including but not limited to my credit history through the national credit bureaus and/or my creditors, verify my criminal background, obtain references from current/past landlords and employers (including income verification), bank and personal references. I hold Back Track Screening, their owners, employees, and their client, harmless for any information shown on my report and any action taken based on that information. I understand that this report will be sent directly to The Housing Authority of the County of Salt Lake and that we cannot receive a copy of this report directly from The Housing Authority of the County of Salt Lake. I understand that I am entitled to a free copy of this report from Back Track Screening if I am denied residency based upon information contained in this report.

Please Print Cleary or Type

Name: _____ _____ _____
LAST FIRST MIDDLE

Social Security # _____ - _____ - _____

Date of Birth* _____/_____/_____
MM DD YYYY

CURRENT ADDRESS

Address _____

City _____ State _____ Zip _____

PREVIOUS ADDRESS HISTORY (WITHIN 7 YEAR PERIOD)

Address _____

City _____ State _____ Zip _____

Address _____

City _____ State _____ Zip _____

Driver's License # _____ State _____

Signature _____ Date: _____/_____/_____

*Date of birth is being requested only for the purpose of identification in obtaining accurate retrieval of records, and will not be used for discriminatory purposes.

FIRST STEP HOUSE

Deposit Assistance Application Form – Central City Apartments

Applicant Name:				
Date Requested:				
Phone:				
Email:				
Currently Employed: ☐ Yes ☐ No If yes, how many hours per week:				
Monthly Employment Income: $				
Other Income: $				
Deposit Resources Available				
Employment	**Family/Friends**	**Ecclesiastical/Church**	**Referring Agency**	**Other**
$_____	$_____	$_____	$_____	$_____
Remaining Amount Requested: $				
Please Note: Deposit requests are not guaranteed. Please utilize all available resources prior to request.				

If you are not approved for deposit assistance, how do you plan on paying for your deposit?

_____ _____

Applicant Signature **Date**

Staff Use Only:

☐ Approved Amount: $_____

☐ Denied

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Definitions

Homeless or Near Homeless Definition

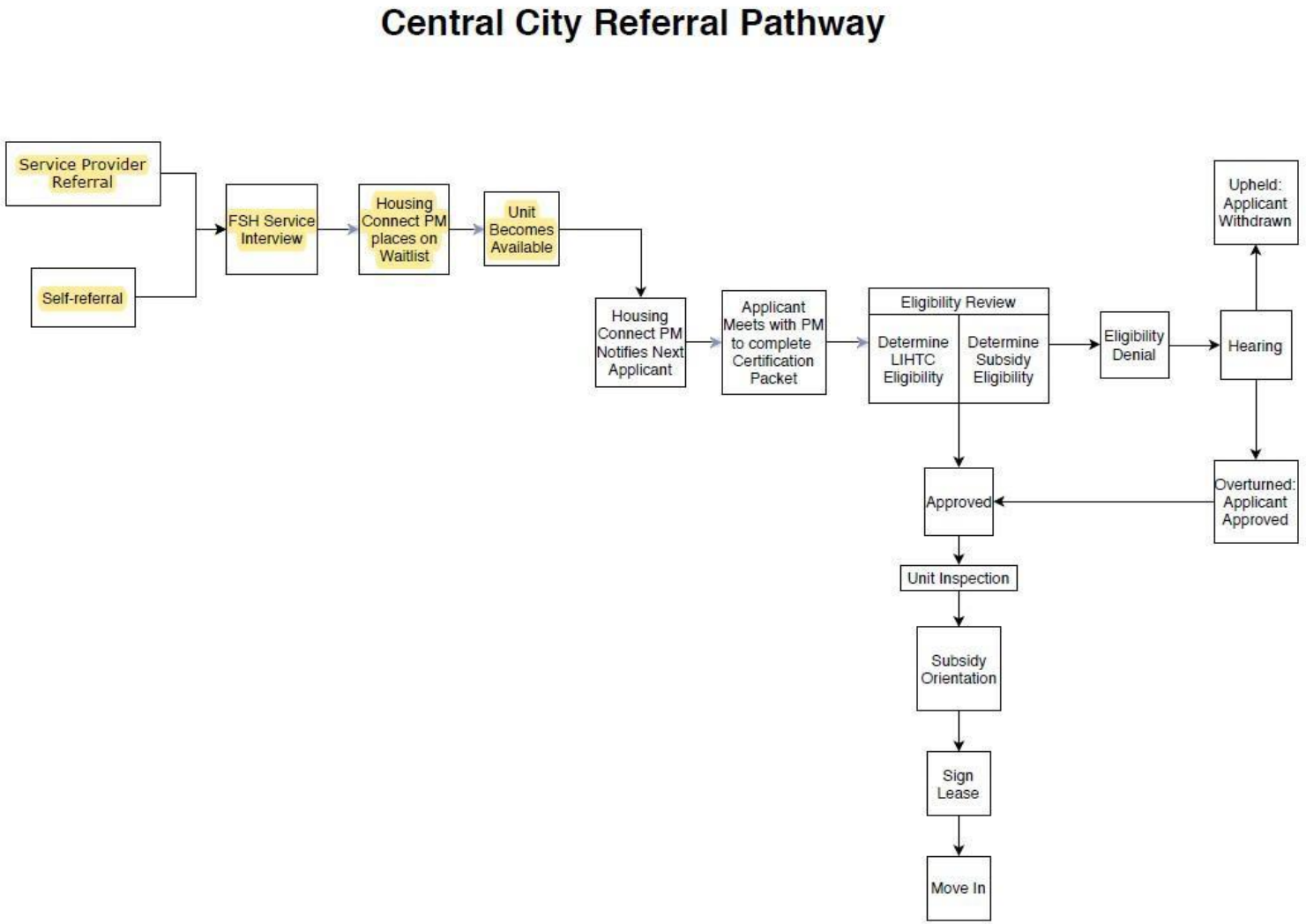
1. An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:
    a. An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;
    b. An individual or family living in a supervised publicly or privately-operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low income individuals); or (iii) An individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution;
2. An individual or family who will imminently lose their primary nighttime residence, provided that:
    a. The primary nighttime residence will be lost within 14 days of the date of application for homeless assistance;
    b. No subsequent residence has been identified; and
    c. The individual or family lacks the resources or support networks, e.g., family, friends, faith-based or other social networks needed to obtain other permanent housing;
    d. Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:
        i. Are defined as homeless under section 387 of the Runaway and Homeless Youth Act (42 U.S.C. 5732a), section 637 of the Head Start Act (42 U.S.C. 9832), section 41403 of the Violence Against Women Act of 1994 (42 U.S.C. 14043e–2), section 330(h) of the Public Health Service Act (42 U.S.C. 254b(h)), section 3 of the Food and Nutrition Act of 2008 (7 U.S.C. 2012), section 17(b) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)), or section 725 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a);
        ii. Have not had a lease, ownership interest, or occupancy agreement in permanent housing at any time during the 60 days immediately preceding the date of application for homeless assistance;
        iii. Have experienced persistent instability as measured by two moves or more during the 60-day period immediately preceding the date of applying for homeless assistance; and
        iv. Can be expected to continue in such status for an extended period of time because of chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse (including neglect), the presence of a child or youth with a disability, or two or more barriers to employment, which include the lack of a high school degree or General Education Development (GED), illiteracy, low English proficiency, a history of incarceration or detention for criminal activity, and a history of unstable employment; or
3. Any individual or family who:
    a. Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence;
    b. Has no other residence; and
    c. Lacks the resources or support networks, e.g., family, friends, faith based or other social networks, to obtain other permanent housing.

Disability / Disabling Coniditon Definition

A condition that:

1. Is expected to be long-continuing or of indefinite duration;
2. Substantially impedes the individual's ability to live independently;
3. Could be improved by the provision of more suitable housing conditions; and
4. Is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, posttraumatic stress disorder, or brain injury

Referral Workflow



FIRST STEP HOUSE

Contact Information

Heatherlee Benson, CMHC
CHARTER Program Manager
hbenson@firststephouse.org
Office: 801-359-8862 X2121
Cell: 385-707-7323

Anna Moody, BS
Program Assistant
amoody@firststephouse.org
liveatcentralcity@firststephouse.org
Office: 801-359-8862 X2145
Cell: 385-377-2491

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Questions?

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Thank you for Your Support!!

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