

SAFE OPTIONS SUPPORT REFERRAL PACKAGE

What is Safe Options Support (SOS)?

- ❖ The SOS program is a mobile outreach team designed to provide intensive support for people experiencing homelessness, that will assist them with accessing housing.
- ❖ The SOS team utilizes a person-centered outreach and engagement approach coupled with a Critical Time Intervention (CTI)- based Model- a time-limited, evidence-based service that helps vulnerable individuals during periods of transition.
- ❖ SOS provides intensive support services (lasting for approximately 9-12 months), with initial outreach and engagement pre-housing, that involves multiple visits per week, and provides 90-day transition services following housing placement, to ensure integration within the community.
- ❖ SOS services and support are client centered and based on client preferences.

Who is Eligible?

- ❖ The SOS Team primarily serves people in need of intensive intervention due to multiple barriers to accessing housing and who are living unsheltered (places not meant for human habitation- cars, tents, etc.)
- ❖ The SOS team must prioritize referrals with the highest level of need and will not be able to enroll every referral we receive
 - People who are receiving Assertive Community Treatment (ACT) are **NOT** eligible for SOS services.
 - People with a primary diagnosis of dementia, intellectual disability, other major neurocognitive disorder or people with severe and persistent cognitive limitations are not best suited for the SOS program

Who can make a Referral?

- ❖ Self or family members,
- ❖ Hospitals and clinics,
- ❖ MTA/LIRR,
- ❖ Law enforcement,
- ❖ Community members or providers,
- ❖ Health Homes, etc.

How to make a Referral?

1. Complete pages 2 and 3 of this referral package
2. Send package to SOS Referral Email: sos-team@addresssthehomeless.org
OR
 - Call SOS Referral Line: 631-464-4314 ext: 170
OR
 - Fax Referral to 631-464-4319



Name of Person Making Referral: _____

What is the Nature of your Relationship with the Applicant? (Social worker, community member, family member, law enforcement, etc.)

If the applicant agrees, would you like to stay in contact with us for updates? ☐ Yes ☐ No

If yes, contact information of Person Making Referral:

Phone #: _____

Email: _____

CONSENT TO RELEASE INFORMATION: I authorize **X**

(referral source) to disclose the completed Safe Options Support Referral Application and all related supporting documents (Application), including confidential medical and mental health information, to the Long Island Coalition for the Homeless (LICH) Safe Options Support team, for the purposes of LICH conducting a clinical assessment and coordinating health care and related services, including community support services and housing placement assistance, for a period of three hundred and sixty five days (365) . As part of this referral process, I understand that LICH will separately obtain my authorization and consent as part of the initial assessment and intake process before providing or coordinating the provision of any additional health care services. I understand that I may revoke my consent to disclose the completed Application at any time. I am aware that my revocation will not be effective if LICH has already received the Application because of my earlier authorization and consent; however, I can instruct LICH to take no further action following its receipt of the Application.

Applicant Name (please print): **X** _____

Applicant Signature: **X** _____

Date: **X** _____

Witness Name (please print): **X** _____

Witness Signature: _____

Date: _____



Applicant Name (alias or street name):

DOB or Age:

Gender: ☐ Male ☐ Female ☐ Transgender ☐ non-Binary ☐ Other:

Address (known location or description of where person is residing):

Client Phone #:

Alternative way to contact (email, alternative #, etc.):

Applicant Primary Language:

Presenting Problem(s):

What barriers is the applicant experiencing that the SOS team can assist with (housing, substance use, behavioral health, chronic health conditions, mobility, etc.)?

(FOR HEALTH CARE PROVIDERS ONLY)

Outpatient Behavioral Health and Medical Clinics / Health Home / Outreach Team / Shelter:

Provider Name:

Address:

Contact Info (Telephone/Email):

Any known Behavioral Health Diagnosis:

Any known Substance Use Diagnoses:



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Any known Medical Disorders:



If you would like to include any relevant supporting documentation to better help us understand background on client (psych evaluation, medical records, etc.), please attach it with referral. Please note this is NOT a requirement of the referral.

Email all documentation to- sos-team@addresssthehomeless.org