

**Lehigh County Clearinghouse Program Referral Form**  
**Lehigh County Conference of Churches, 534 W. Chew Street, Allentown, PA 18102**  
**Phone: 610-841-1370 Fax: 610-841-1377 Web: [www.lehighchurches.org](http://www.lehighchurches.org)**

NAME OF INDIVIDUAL BEING REFERRED: \_\_\_\_\_

DATE OF REFERRAL: \_\_\_\_\_

**Eligibility Checklist**

The Lehigh County Clearinghouse Program will provide equal priority for the MA eligible populations identified below. This includes people who have a serious and persistent mental illness who are\*:

1. Young Adult, (Age 18-23) transitioning from services population – **or** –
2. Currently in Community Rehabilitation Residences (CRR), whose housing and service needs can be more appropriately met in Permanent Supportive Housing (PSH) – **or** –
3. Forensic Population transitioning out of Lehigh County Prison – **or** –
4. Homeless, or at risk of homelessness

\*Documentation on agency letterhead stating population is required. Attached  yes  no

Additionally must meet the following criteria:

1. Extremely low income (<30% Area Median Income limit)

**If an answer of “no” is provided for any of the questions below, this person might not meet the program’s entry requirement. If you are in doubt, please contact the program for assistance completing this referral.**

- 1) Does this individual meet MA eligibility in Lehigh County

**Yes No (circle one)**

- 2) Does this person have a serious and persistent mental illness and belong to one of the following populations:

- a) Young adult Young Adult, (Age 18-23)
- b) Currently in Community Rehabilitation Residence (CRR)
- c) Forensic Population transitioning out of Lehigh County Prison
- d) Homeless or at risk of homelessness

**Yes No (Serious Mental Illness)**

**Specify Population \_\_\_\_\_**

- 3) Meets the criteria for extremely low income (<30% Area Median Income limit)

**Yes No (circle one)**

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Date of Referral: \_\_\_\_\_

County: \_\_\_\_\_

Name: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

Address: (Where this person can be reached)  
 \_\_\_\_\_  
 \_\_\_\_\_

SS#: \_\_\_\_\_

Phone: \_\_\_\_\_

Veteran Status: \_\_\_\_\_

(Where this person can be reached)

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**HOUSEHOLD INFORMATION**

Please list all household members' names, DOB, SS#, income. \* Proof of Identity and Income for all household members is required.

NAME	Relationship	DOB	SS#	Income Amount/Source	Identification/Income Attached
					<input type="checkbox"/> yes <input type="checkbox"/> no
					<input type="checkbox"/> yes <input type="checkbox"/> no
					<input type="checkbox"/> yes <input type="checkbox"/> no
					<input type="checkbox"/> yes <input type="checkbox"/> no
					<input type="checkbox"/> yes <input type="checkbox"/> no
					<input type="checkbox"/> yes <input type="checkbox"/> no
					<input type="checkbox"/> yes <input type="checkbox"/> no

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**Reason for Referral:**

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Referral Person: \_\_\_\_\_ Phone/ Pager #: \_\_\_\_\_

Referral Agency: \_\_\_\_\_

Address: \_\_\_\_\_

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**MEDICAL INFORMATION**

Referrals must include documentation of ongoing, serious and persistent mental illness.

\*A psychiatric evaluation within 2 years is considered to be proof of serious persistent mental illness.

Attached:     yes  no

Current/Ongoing  
Mental Health Treatment: Yes\_\_\_ No\_\_\_  
Phone\_\_\_\_\_

Case Worker\_\_\_\_\_

Agency\_\_\_\_\_

Provider\_\_\_\_\_

Current/Ongoing  
Drug/Alcohol Treatment: Yes\_\_\_ No\_\_\_  
Phone\_\_\_\_\_

Case Worker\_\_\_\_\_

Agency\_\_\_\_\_

Provider\_\_\_\_\_

Current/Ongoing  
Court Supervision:        Yes\_\_\_ No\_\_\_  
Phone\_\_\_\_\_

Probation/ Parole Officer\_\_\_\_\_

County of Supervision\_\_\_\_\_

Does this person need long-term supports and services in order to live as independently as possible?  
Yes\_\_\_ No\_\_\_

Please describe the long-term supports needed.

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