COMMUNITY HIGH RISK REFERRAL SCREENING FORM

AIP NAME: _____

Is the AIP (alleged incapacitated person) and APS (adult protective services) referral OR had an open APS case in the past 6 months? ☐ YES ☐ NO ☐ UNK

Has the AIP had 2 or more hospitalizations within the past year (medical or voluntary mental health/substance abuse treatment)? ☐ YES ☐ NO ☐ UNK

Has the AIP had 2 or more ER (emergency room) visits in the past 6 months? ☐ YES ☐ NO ☐ UNK

Has the AIP been Baker Acted in the past 6 months? ☐ YES ☐ NO ☐ UNK

Has the AIP had 1 or more arrest in the past 6 months? ☐ YES ☐ NO ☐ UNK

If the answer is "YES" to any of the above criteria, the AIP will be considered a **COMMUNITY HIGH RISK**

HOMELESSNESS RISK ASSESSMENT

Currently homeless? ☐ YES ☐ NO ☐ UNK

Eviction/foreclosure/shut-off notice pending? ☐ YES ☐ NO ☐ UNK

In hospital w/no safe discharge plan? ☐ YES ☐ NO ☐ UNK

Unable to manage/pay current living expenses? ☐ YES ☐ NO ☐ UNK

If the answer is "YES" to any of the above criteria, the AIP is considered a **POTENTIALLY HOMELESS INDIVIDUAL**