PILOT FORM 8/21/23 - 8/25/23

CAFES COHORT III PARTICIPATION FORM (Form CC3)

(Combined form for CAFES Eligibility, Services, and Payment Authorization)

SECTION 1: CLIENT ELIGIBLITY REQUEST

Client Name: ______________________ DOB: _______ Language: ________ P#________ S# ____________

Address: ______________________________________ In Custody? ☐ Yes ____________ ☐ No
Location

Race/Ethnicity: ________ Gender: _____ Social Security #: ____________ Pending Court Date? ____________
Date

Is client currently on AB109 Supervision (or have they previously been on): ___ PRCS ___ 1170

Identified Criminogenic Needs (CAIS): ____

Court Case No(s):______________________ Collaborative Court No.:________________ Avatar ID: _________

Client Status & Goals: Housing: ____________________________________ Housing Goal: ____________________

Education: Highest Education Level: ___________ Education Status & Goals: ______________________________

Employment: ☐ Part-time ☐ Full-time ☐ Unemployed Employment Status & Goals: ____________________

Other/Comments: ____

Eligibility Factors (Mark all that apply)

☐ Recently Cited/Arrested

☐ Collaborative Court

☐ Probation (Supervision/Monitoring)

List current offenses & dates below or attach court minutes/documentation of charge/conviction:

____

____

☐ Prior Arrests

☐ Prior Conviction(s)

Needs:

☐ Identified Mental Health

☐ Identified Substance Use Disorder

☐ Suspected Mental Health

☐ Suspected Substance Use Disorder

☐ Identified Housing Need

Explain how housing will support SUD or MH Treatment below:

____

____

____

____

☐ Substance Use Disorder assessment completed on: __________ Tool Used:_________________ ☐ Not completed

☐ Mental Health assessment completed on: ___________ Tool Used:______________________ ☐ Not completed

☐ Other assessment completed on: ___________ Tool Used: ________ ☐ Not completed

SUD Tx Recommendations: **Level**: ☐Detox ☐Residential ☐Outpatient **Length**: # Days:___ Begin Date: __________

Does Client receive or have access to any other funding/resources (if yes, explain)? ☐ Yes ☐ No

Explain: ____

____

SECTION 1: CLIENT ELIGIBLITY REQUEST (continued)

Services Requested: *(Prioritize and select only top 3)*

☐ Assessment – MH	☐ Employment Services	☐ Other Support Services
☐ Assessment - SUD	☐ Family Services	☐ Re-entry Services
☐ Basic Necessities	☐ Food Assistance	☐ Sober Living Environment
☐ Bridge Housing/Hotel	☐ Health Services	☐ Social Services
☐ Case Management	☐ Housing Support	☐ SUD (see level above)
☐ Case Plan for MH	☐ Legal Services	☐ Transportation Assistance
☐Diversion Program	☐ Mental Health Treatment	

Client Eligibility Request Completed by:

Printed Name: ______________________ **Title:** ____________________ **Organization:** ___________________

Signature: __________________________ **Date:** __________ **Phone**: __________ **Email:** __________________

INSTRUCTIONS: *Complete Section 1 and submit the entire Form CC3 with the required signed Release of Information and court minutes or documentation of charge conviction via DocuSign to PRBCAFESRequests@santacruzcounty.us.*

The request will be reviewed, the approvals section completed, and returned to requestor via DocuSign.

APPROVALS (Completed by CAFES Connector Team (CCT) or CAFES Grant Manager (CGM))

ELIGIBLITY: ☐ **APPROVED** ☐ **NOT APPROVED** Reason: _____________________________________

SERVICES: ☐ **APPROVED AS REQUESTED (above)** ☐ **APPROVED AS MODIFIED (see below)** ☐ **NOT APPROVED**

Service(s) approved as modified: ____

Service(s) Approval Period: From: _________ To: __________

Approved By:

Printed Name: ______________________ **Title:** _______________________ ☐ CCT or ☐ CGM

Signature: __________________________ **Date:** __________ **Phone**: __________ **Email:** __________________

Individuals with Medi-Cal eligibility that are inactive, out-of-county, or have not applied MUST take steps to apply for and/or reinstate these benefits in order to be considered for any extensions to CAFES funding. Please advise if support is needed for this process.

SECTION 2: REQUEST FOR AUTHORIZATION OF SERVICES

Program or Housing: ______________________________ Projected Intake Date: ________________

Payee Name: ____

Payee Address: ____

Contact Name: _________________ Email: _________________________ Phone No.: ____________

Requested by: __________________ Email: __________________________ Phone No.: ____________

AUTHORIZATION (Completed by CAFES Connector Team (CCT) or CAFES Grant Manager (CGM)

All referrals to Janus Treatment and SLE services must be approved by CAFES Grant Manager

Authorization No.: ______________ Authorized Start Date: __________ Authorized End Date: ________

No. Days/Nights Authorized: _______ Rate: $_______ ☐Monthly ☐Daily ROI Signed? ☐ Yes ☐ No

Manager: _____________________ ☐ CCT or ☐ CGM Email: ___________________ Phone: _____________

SECTION 3: REQUEST FOR PAYMENT

Completed by Program and submitted for authorization to Janus Payee Team (JPT) or CGM within 5 days of client departure.

ACTUAL DATES: ***Entry*_______ *Departure*_______ \ QTY**: ___ ☐ **Days** or ☐ **Mos. \ TOTAL COST: $**___________

Client Goals Completed at Exit/Completion of Treatment/Housing:

Goals Completed: (Check all goals completed)s: ☐ Education ☐ Housing ☐ Employment ☐ None

Client Status at Exit/Completion of Treatment/Housing:

Housing: ☐ Homeless ☐ Lives w/family ☐ Independent Housing ☐ Residential Treatment ☐ None ☐ Sober Living Housing ☐ Transitional Housing ☐ Bridge Housing ☐ Other ______________

Employment: ☐ Part-time ☐ Full-time ☐ Unemployed Education: **Highest Education Level**: __________

Comments: ____

ASSURANCES: The signatures below verify that participant has ☐ **ENTERED** ☐ **REMAINED IN** ☐ **DEPARTED FROM** Program at the date of signature, and that program is entitled to payment as authorized in this document. Participant is advised that after the authorized number of consecutive days has expired, participant is responsible for payment and for arranging a continued stay at the program.

Program Manager: ___________________________ \ ______________________________ \ ______________
Printed Name *Signature* *Date Signed*

Participant: ___________________________ \ ______________________________ \ ______________
Printed Name *Signature* *Date Signed*

AUTHORIZATION FOR PAYMENT (Completed by JPT or CGM)

Approved by: ________________________ \ ________________________ ☐JPT or ☐ CGM \ _______________
Printed Name *Signature* *Date Signed*

Title:_______________________ Email: _______________________________ Phone: ________________

Email Request for Payment (Section 3) to PRBCAFESREQUESTS@SANTACRUZCOUNTY.US