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: _____ Phone:_____ 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