



**Transitional Living Services of Northern New York**  
 482 Black River Parkway  
 WATERTOWN, NEW YORK 13601  
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**SUPPORTED HOUSING PROGRAM**  
**ELIGIBILITY CRITERIA**

**To be considered an adult diagnosed with a severe and persistent mental illness A must be met and B or C or D must be met. Please fill in the individual Psychiatric Diagnosis and Code in the space provided and check all applicable criteria.**

\_\_\_\_\_A. Designated Mental Illness Diagnosis: The individual must be 18 years of age and currently meets the criteria for a DSM-IV psychiatric diagnosis other than alcohol or drug disorders, organic brain syndromes, developmental disabilities, or personality disorders. ICD-9-CM categories and codes that do not have an equivalent in DSM-IV are also NOT included as designated mental illness diagnoses.

Diagnosis: \_\_\_\_\_ Code: \_\_\_\_\_

\_\_\_\_\_B. SSI or SSDI Enrollment due to Mental Illness: The individual is currently enrolled in SSI or SSDI due to a designated mental illness.

\_\_\_\_\_C. Extended Impairment in Functioning due to Mental Illness: The individual must meet 1 or 2 below:

1. The individual must be functionally disabled due to mental illness for at least the past twelve months either continuously or intermittently in at least two of the following areas: Self Care; Social Functioning; Activities of Daily Living; Ability to Concentrate

2. The individual has met the criteria for ratings of 50 or less on the Global Assessment of Functioning Scale due to a designated mental illness over the past twelve months on a continuous or intermittent basis.

\_\_\_\_\_D. Reliance on Psychiatric Treatment, Rehabilitation and Supports: A documented history shows the individual at some point prior, met the threshold for C (above), but symptoms and/or functioning problems are currently attenuated by medication or psychiatric rehabilitation and supports.

**I verify that this individual has a severe and persistent mental illness and meets the eligibility criteria.**

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

**DOB:** \_\_\_\_\_

**Signature of Registered Nurse, LMSW, LCSW, Psychiatrist, or Psychologist**

\_\_\_\_\_

**License Number**

\_\_\_\_\_

**Please Print Name**

\_\_\_\_\_

**Date**

\_\_\_\_\_