

Agency Referral

Date _____

To be completed by Approved Referring Agency only. Please type or print neatly.

Referred by: _____

Agency: _____

Contact Person: _____

Phone: _____

Mailing Address _____

Head of Household:

Mother's Last Name: _____ First: _____ sex age DOB

Social Security#: _____ US Citizen? Yes ___ : No ___ : Marital : **S M D W**

Father's Last Name: _____ First: _____ sex age DOB

Social Security#: _____ US Citizen? Yes ___ : No ___ : Marital : **S M D W**

Current Family Address _____ Phone Number _____

Other Adults in family:

Last Name: _____ First: _____ sex age DOB Relationship

In Case of emergency:

Last Name: _____ First: _____ Phone Number: _____ Relationship _____

Information on Children:

Child(ren) present:

Name:	Sex	DOB	School/grade or Childcare
1. _____	m f	_____	_____
2. _____	m f	_____	_____
3. _____	m f	_____	_____
4. _____	m f	_____	_____
5. _____	m f	_____	_____

House The Children

Is mother currently pregnant? _____ If yes, what is her due date? _____.

Are all children staying with the Parent(s)? _____ If no, please attach explanation.

Ethnicity:

_____ Black _____ Hispanic _____ Caucasian _____ Native American
_____ Asian _____ Other _____
Please Specify Please Specify

Current Situation:

Where is family staying? _____

Date family became initially homeless: _____. How long has the family been homeless _____.

What led to current homelessness? (Please be Specific)

Time remaining at current residence: _____ Can stay be extended? _____

Employment:

Are adults in family currently employed? _____ If so, where?

Family Monthly Budget:

Income:
Salary _____
Other Salary _____
TANF _____
Child Support _____
Social Sec./Disability _____
SSI _____
Food Stamps _____
Other Income _____
TOTAL INCOME _____

Expenses:
Rent _____
Clothing _____
Food _____
Transportation _____
Other (debts) _____
Other _____
Other _____
TOTAL EXPENSES: _____

House The Children

How often does family receive income? _____ daily _____ weekly _____ 2x/month
_____ monthly.

Resources:

Has client used services of other local agencies in the last 12 months? _____ If yes, please list.

Agency/Program

Dates

DSS Caseworker: _____ County: _____

Veteran in family? _____ If yes, please give her/his name: _____

Health:

Parent enrolled on health plan: (private, state, federal): _____

Children enrolled on health plan: (private, state, federal): _____

Do any of the family members take medication? _____ If yes, what type and for what condition.

Has any family member been a victim or perpetrator of domestic violence (spouse or child abuse)?

_____ If yes, please give dates and interventions, if any _____

History of drug/alcohol abuse in the family? _____ If yes, please explain: _____

How long has family member been sober or chemically free? _____

If chemically dependant, does client attend support groups? _____ If yes. How often per month? _____

Does this person have a sponsor? _____ If yes, name _____ phone number _____

History of mental health problems in the family? _____ If yes, please explain: _____

HOUSE THE CHILDREN AT THE BASSETT CENTER

VERIFICATION OF HOMELESSNESS

Applicant: _____ Program: _____

Indicate which situation described below best describes the living situation of the applicant and attach to this form any accompanying documentation:

_____ **A place not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings (on the street).** Certification form signed by the outreach worker or service worker verifying that the person or family is homeless. This could include a letter or certification form signed by an outreach worker or service worker from another organization that can verify that the person or family was, in fact, homeless as described in the above definition, or a written statement prepared by the participant about the participant's previous living place (if unable to verify by outreach worker or service worker). Have the participant sign and date.

_____ **An emergency shelter.** Shelter operator certification that the participant has been residing at the emergency shelter (on agency letterhead, signed and dated)

_____ **A transitional or supportive housing program for homeless persons who originally came from the streets or emergency shelters (make sure you have evidence that the person came from the streets or emergency shelter situation).** Certification (on agency letterhead, signed and dated) if the participant is residing at the transitional housing facility as well as written verification that the participant was living on the streets or an emergency shelter prior to living in the transitional housing facility (see above for required documentation).

_____ **In any of the above places but is spending a short time (up to 30 consecutive days) in a hospital or other institution.** Certification from institution's staff verifying that the participant has been residing in the institution for 30 days or less. There should also be written verification that the participant was residing on the street or in an emergency shelter prior to the short-term stay in the institution.

_____ **Is being evicted within a week from a private dwelling unit and no subsequent residence has been identified and the person lacks the resources and support networks needed to obtain housing.** Eviction statement describing the reason for eviction (signed and dated by person evicting). No formal eviction is required. If unable to obtain an eviction statement, you must obtain a written statement signed and dated by the participant describing the situation. Outreach worker or service worker must document their efforts by providing a verification form documenting that they have made every effort to confirm that the circumstances are true and have written verification describing the efforts and attesting to their validity. The verification form should be signed and dated. You must also have information on the income of the participant to verify that they lack the financial resources and support networks needed to obtain housing.

_____ **Is being discharged within a week from an institution, such as a mental health or substance abuse treatment facility or a jail/prison, in which the person has been a resident for more than 30 consecutive days and no subsequent residence has been identified and the person lacks the resources and support networks needed to obtain housing.** Certification completed by institution staff stating that the participant was being discharged within the week before receiving assistance. You must also have information on the income of the participant to verify that they lack the financial resources and support networks needed to obtain housing, documentation of efforts to obtain housing and that without the assistance, the participant would be living on the street or in an emergency shelter.

_____ **Is fleeing a domestic violence housing situation, no subsequent residence has been identified and the person lacks the resources and support networks needed to obtain housing.** Statement from the participant that he/she is fleeing a domestic violence situation. If participant is unable to prepare a written statement, staff should prepare the statement about the participant's previous living situation and have the participant sign and date it.

The applicant is hereby certified to be homeless according to the above conditions:

Verified by: _____ Agency: _____ Date: _____