

**SHELTER INC. REFERRAL FORM**

Referring Agency \_\_\_\_\_ Contact: \_\_\_\_\_ Date: \_\_\_\_\_

Agency Phone # \_\_\_\_\_

Client Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Ph ( ) \_\_\_\_\_ Work Ph ( ) \_\_\_\_\_ Message ( ) \_\_\_\_\_

Client Name #2 \_\_\_\_\_ Last Name \_\_\_\_\_

Household Size \_\_\_\_\_ Number of Children (living with you) \_\_\_\_\_

		Children	Name	DOB	Sex
<b>Income</b>	<b>Amount.</b>	1.	_____	_____	_____
1 _____	_____	2.	_____	_____	_____
2 _____	_____	3.	_____	_____	_____
3 _____	_____	4.	_____	_____	_____
4 _____	_____	5.	_____	_____	_____
5 _____	_____	6.	_____	_____	_____
		7.	_____	_____	_____
<b>Total Monthly Household income</b> _____		8.	_____	_____	_____

**A. HOUSING**

1. Where did you/the family sleep last night? \_\_\_\_\_

Address: \_\_\_\_\_

2. Date you became homeless: \_\_\_\_\_ Last permanent Residence (rent/mortgage/friend/family)

Address: \_\_\_\_\_

3. If not homeless yet, date will become homeless: \_\_\_\_\_

4. Reasons for homelessness: \_\_\_\_\_

**Note:** If a safe house (unpublished address) is needed, this is not an appropriate referral.

5. Have you ever stayed at a SHELTER, Inc. program? \_\_\_\_\_ Which one? \_\_\_\_\_

**B. INCOME & EMPLOYMENT**

1. Where do you work?: Adult 1 \_\_\_\_\_

2. If working, how long ago?: Adult 1 \_\_\_\_\_

3. If not working, how long did you work in your last job and where? Adult 1 \_\_\_\_\_

4. Reason for job ending: Adult 1 \_\_\_\_\_

**C. HEALTH HISTORY (Specify Adult 1 or 2 or Child 1-9 when answering questions.)**

1. Do you or any family member have any health problems that could affect your or their own participation in the program?

List member(s) and specific health problems \_\_\_\_\_

**D. ALCOHOL & DRUG HISTORY (Specify Adult 1 or 2 or Child 1-9 when answering questions.)**

1. When was the last time (include social use) any family member used alcohol or drugs? List family member(s), date and describe use of drugs and or alcohol (frequency, amounts): : \_\_\_\_\_

2. Describe present use of drugs (frequency, amounts): \_\_\_\_\_

3. If not in treatment, are they interested in obtaining treatment? YES \_\_\_ NO \_\_\_

**E. PRIORITY CONSIDERATIONS**

\_\_\_ Pregnant (# of mos. : \_\_\_)

\_\_\_ Infant in the family (how old? \_\_\_)

\_\_\_ sleeping on street or in vehicle

\_\_\_ Medical risk (describe: \_\_\_\_\_)

**Does the client have transportation:** Yes or No If yes what kind of transportation:

**F. ADDITIONAL COMMENTS:** \_\_\_\_\_

- G.** Please list all agencies, workers names & numbers client is currently working with that will be able to assist in helping the client(s) achieve permanent housing:

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

***REFERRAL WILL EXPIRE AFTER 90 DAYS***

\_\_\_\_\_  
Signature of Adult #1

**Note: Please mail original intake to 1815 Arnold Dr. Martinez, CA. 94553.** Please ask clients to provide picture ID, proof of income & homelessness (eviction notice, homeless verification, etc.).

**If there are two adults in the same household, please fill out one form for each.**

7/18/07