

HOUSING AUTHORITY OF THE COUNTY OF SAN MATEO



REFERRAL FORM

For Supportive Housing Programs (S+C and SHP)
(Please complete all sections and provide appropriate attachments)



Client Name: _____ Referral Date: _____

Client Address: _____

Client Phone Number: _____ Alternate Phone Number: _____

SSN: _____ DOB: _____

Primary Contact Person for Client (e.g. their case manager): _____

Title: _____ Phone Number: _____

Referring Agency: _____

Referring Agency Address: _____

Name of Person Making Referral: _____

Title: _____ Phone Number: _____

Program: S+C
 SHP

If S+C, Indicate Unit Type: Tenant-Based (TRA)
 Sponsor-Based (SRA)
 Project –Based (Belmont Apts)

Special Needs:

Please check all that apply:

- a. Mental Illness
- b. Alcohol Abuse
- c. Drug Abuse
- d. HIV/AIDS and related diseases
- e. Developmental disability
- f. Physical disability
- g. Domestic violence
- h. Other (please specify) _____

Prior Living Situation:

Where did the client sleep in the week prior to being referred to the S+C/SHP program?

- a. Non-housing (street, park, car, bus station, etc.)
- b. Emergency shelter
- c. Transitional housing for homeless persons
- d. Psychiatric facility*
- e. Substance abuse treatment facility*
- f. Hospital*
- g. Jail/prison*
- h. Domestic violence situation
- i. Living with relatives/friends
- j. Rental housing
- k. Other (please specify) _____

**If the client is coming from one of these institutions but was there less than 31 consecutive days and was living in the street or emergency shelter prior to entering the treatment facility, please check a. or b., as appropriate.*

Is the client a chronically homeless person? Yes No

A chronically homeless person is an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least four (4) episodes of homelessness in the past three (3) years. To be considered chronically homeless, a person must have been on the streets or in an emergency shelter (i.e. not transitional housing) during these stays.



Demographics

Rehabilitation Team: Please provide the name, address and phone number of the following:

*Please place an * next to the name of the Care Coordinator*

Case Manager: _____

Psychiatrist: _____

Therapist & Region _____

Vocational Counselor: _____

Rep Payee: _____

Conservator: _____

Race:

Please check all that apply

- a. American Indian or Alaskan Native
- b. Asian
- c. Black or African-American
- d. Native Hawaiian or Other Pacific Islander
- e. White

Ethnicity:

- a. Hispanic or Latino
- b. Non-Hispanic or Non-Latino

Marital Status: _____ Primary Language: _____

Is the client a veteran? Yes No If yes, does client receive VA services? Yes No

If yes, what kind? _____

Financial Information

1. Gross Monthly Income: _____
2. Sources of Income (please check all that apply):
 GA SSI SDI VA Job Social Security Family Other
3. Is client under Rep Payee? Yes No If yes, provide name , address and phone above.
4. Is SSI Pending? Yes No If yes, expected approval date: _____

Employment Status

Please check one:

- | | |
|--|---|
| <input type="checkbox"/> Paid Employment (35+ hours/week) | <input type="checkbox"/> Volunteer work (less than 35 hours/week) |
| <input type="checkbox"/> Paid Employment (less than 35 hours/week) | <input type="checkbox"/> Not in labor force |
| <input type="checkbox"/> Volunteer work (more than 35 hours/week) | <input type="checkbox"/> Unemployed |

Social Support

Sources of social support (e.g. friends, church group): _____

Current activities: _____



Housing History

List the address where client is currently living. If client is staying at a shelter or in transitional housing, list the name and address of the agency:

1. Address: _____
Move in Date: _____
Landlord/Operator _____ Phone #: _____

For **the past 3 years**, list the places the client has lived and the circumstances for leaving:
(use a separate page if needed):

2. Address: _____
Move in Date: _____ Move out Date: _____
Landlord/Operator _____ Phone #: _____
Reason for Leaving: _____

Address: _____
Move in Date: _____ Move out Date: _____
Landlord/Operator _____ Phone #: _____
Reason for Leaving: _____

Address: _____
Move in Date: _____ Move out Date: _____
Landlord/Operator _____ Phone #: _____
Reason for Leaving: _____

3. If client lived in the streets or non-housing (park, car, bus station, etc.) for brief periods of time or intermittently, list the location and length of stay for each episode (use a separate page if needed):

4. Has client ever applied for or participated in any rental assistance programs? Yes No

If yes, list program type and date of application/participation: _____

If yes, why was client not accepted or why didn't it work out? _____

5. Are there any patterns of client behavior that interfere with community living? _____

6. What are the client's major strengths for independent community living? _____



Information on Additional Persons in Household
(If there are no other persons in the household, do not complete this page)



If there will be any other adults living with the client while on housing assistance (i.e. a spouse, partner, sibling, parent), provide the following information for each adult. Include information on attendants or children 18 or younger at the bottom of the page. Use additional sheets if necessary.

Name: _____

Relationship to Client: _____

SSN: _____ D.O.B.: _____ Is the person a veteran? Yes No

Is the person chronically homeless? Yes No (See definition on page 1)

Race:

Please check all that apply

- a. American Indian or Alaskan Native
- b. Asian
- c. Black or African-American
- d. Native Hawaiian or Other Pacific Islander
- e. White

Ethnicity:

- a. Hispanic or Latino
- b. Non-Hispanic or Non-Latino

Special Needs:

Please check all that apply:

- a. Mental Illness
- b. Alcohol Abuse
- c. Drug Abuse
- d. HIV/AIDS and related diseases
- e. Developmental disability
- f. Physical disability
- g. Domestic violence
- h. Other (please specify) _____

Prior Living Situation:

Where did the person sleep in the week prior to being referred to the S+C/SHP program?

- a. Non-housing (street, park, car, bus station, etc.)
- b. Emergency shelter
- c. Transitional housing for homeless persons
- d. *Psychiatric facility**
- e. *Substance abuse treatment facility**
- f. *Hospital**
- g. *Jail/prison**
- h. Domestic violence situation
- i. Living with relatives/friends
- j. Rental housing
- k. Other (please specify) _____

**If the person is coming from one of these institutions but was there less than 31 days and was living in the street or emergency shelter prior to entering the treatment facility, please check a. or b., as appropriate.*

Other Persons Who Will Reside In Household

	Name	SSN	Gender	Relationship to Client	D.O.B.
1.					
2.					
3.					
4.					



Mental Health History

Diagnosis:

Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: _____

Please include any and all drug and alcohol diagnoses on Axis I, whether bingeing or dependence. These diagnoses do not exclude your client from consideration for the S+C Program.

Current Psychiatric Medications and Dosage:

Prescribed By:

1. _____
2. _____

Other Medications and Dosage:

Prescribed By:

1. _____
2. _____
3. _____

Response to medications: Symptoms alleviated Symptoms Persistent

If persistent, please describe: _____

Does the client know how/remember to take medications as prescribed? Yes No

Is the client willing to take medications as prescribed? Yes No

Number of previous psychiatric hospitalizations: _____

Circumstances and date of most recent hospitalization: _____

Number of previous suicide attempts: _____ Date of most recent attempt: _____

Please describe: _____

Signs of Decompensation (please be as specific as possible): _____

Any incidents of violence towards self or others? Yes No Date of most recent incident: _____

If yes, please describe: _____

Alcohol and Other Drugs

1. Does client have a history of drug or alcohol abuse? Yes No

List type: _____

If yes, referral must include a **Recovery Plan statement** written and signed by client.

2. Has client received treatment? Yes No

If yes, list program and date(s) of treatment: _____

3. How long has client been clean and sober? _____

4. Are random drug tests being done? Yes No

Probation/Parole Officer: _____

HOMELESS CERTIFICATION

For Supportive Housing Programs

(Please complete all sections including signatures and appropriate attachments)

Client Name _____ is currently *(check on of the boxes below)*

- a. Sleeping in an emergency shelter
If you check this box, the certification must be signed by a staff member of the emergency shelter in which the client is residing.
- b. Sleeping in places not meant for human habitation (such as cars, parks, sidewalks, etc.)
If you check this box, the certification must be signed by a staff member of an organization that is providing services to the person and can attest that he or she is homeless.
- c. Living in transitional housing for homeless persons, having come from a shelter or place not meant for human habitation.
If you check this box, the certification must be signed by a staff member of the transitional housing program in which the client is residing. The program must have documentation on file that the individual was homeless at the time he or she entered.

I certify that the above information is correct to the best of my knowledge and that I have the appropriate documentation on file.

Signature

Date

Printed Name

Title

Address

Agency Name

City, State, Zip

(____)_____
Phone

HOUSING AUTHORITY OF THE COUNTY OF SAN MATEO

DISABILITY CERTIFICATION For Supportive Housing Programs (S+C and SHP) *(Please complete all sections including signatures)*

Client Name: _____

1. I certify that the above named client is disabled, because (check one of the boxes below):

If you check box a, you must attach a copy of the client's SSI determination letter.

- a. The client is receiving Supplemental Security Income (SSI) benefits or has been determined to be eligible for SSI benefits.

If you check box b, the certification must be signed by a credentialed psychiatric or medical professional trained to make such a determination.

- b. The client is not receiving SSI benefits but meets the following definition of disability:

“A person shall be considered to have a disability if such person (1) has a physical, mental, or emotional impairment which is expected to be of long-continued and indefinite duration; substantially impedes his or her ability to live independently; and is of such nature that such ability could be improved by more suitable housing conditions, or (2) has a developmental disability; or (3) has AIDS or conditions arising from its etiological effects.

2. Please indicate the type of disability (you may check more than one box):

- a. SMI (Serious Mental Illness)
 b. CSA (Chronic Substance Abuse)
 c. SMI & CSA (Serious Mental Illness & Chronic Substance Abuse)
 d. PWA (Persons with AIDS or Related Diseases)
 e. PWOD (Persons with Other Disabilities)

Please complete and sign below to certify your choice in section 1.

Signature

Date

Printed Name

Title

Address

(____) _____
Phone

City, State, Zip

