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| **A picture containing circle  Description automatically generated** | **HOST PROGRAM**  **(Homeless Outreach Stabilization & Transition)**  **Referral Form** |

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| **Submit Referrals by—** | **Email:** HOST@tmbho.org | **Phone**: 360-764-6282 |
| **Eligibility Determination** | | |
| **Person appears to be experiencing pervasive and persistent symptoms of a known or unknown substance use and/or mental illness.**  **Person is not receiving services with another agency.** HOST cannot register an individual who is already registered with another agency. Exceptions include individuals who are unable to engage with their current mental health provider and/or if the individual is scheduled to be exited soon (please provide current case manager’s name & phone number.  **Person is currently homeless or at imminent risk of homelessness (i.e. undergoing eviction process).** | | |

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| **Referral Source Information** | | | | | |
| **Referring Agency/Individual:** |  | | | **Date of Referral:** |  |
| **Phone Number:** |  | | | **Email:** |  |
| **Additional Contacts** | | | | | |
| **Name:** |  | | | **Phone/Email:** |  |
| **Referred Individual’s Information** | | | | | |
| **Referred Individual’s Name (or nickname):** | |  | | | |
| **\*Referred Individual’s DOB, age, or estimated age:** | |  | | | |
| **\*Location** (where the referred individual can be found, include dates/times, if known; if in facility, include d/c date)**:** | | | | | |
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| **\*Primary Reason for Referral** (include any mental health symptoms you have observed & why traditional services have been/would be unsuccessful)**:** | | | | | |
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| **\*Physical Description** (i.e. estimated weight, height, race, gender, hair color/style, clothing, notable belongings (i.e. “red backpack, lots of trash bags”), and other identifying features (i.e. scars, tattoos, etc.) please note whether observed or reported)**:** | | | | | |
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| **Outreach/Engagement Strategies**  (i.e. “This person really likes soda”, “This person likes to talk about jewelry”, “This person fears the government”)**:** | | | | | |
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| **Referred Individual’s Clinical History (if known)** | | | | | |
| **Mental Health History** (incl. past and current diagnoses)**:** | | | **Substance Use History** (incl. past and current substance use)**:** | | |
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| **Risk Assessment** (incl. Assault History, Criminal History, Current or Past Suicidal or Homicidal Ideation or Behavior)**:** | | | **Current Funding & Income** (incl. pending applications & Medicaid-status)**:** | | |
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**\*Indicates required field**

If you require additional space, please attach separate sheets clearly marked with your name and contact details.

**Disclaimer:** In compliance with HIPAA regulations we may not always be able to provide information on the outcome of a referral. In addition, as defined in RCW 26.44.030, staff are mandated reporters and are required to report and disclose any information or suspicion regarding the abuse or neglect of a child or vulnerable adult to relevant authorities.