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| **Referral Information** | | | | | | |
| **Which Housing Program is this referral for?**  Housing and Recovery through Peer Supports (HARPS)  Community Behavioral Rental Assistance (CBRA)- Please check website to confirm we are accepting referrals | | | | | | |
| **Referral Source Name:** (if this is a referral for you, write self) | | | |  | | |
| **Referral Source Agency:** (if this is a referral for you, write self) | | | |  | | |
| **Referral Source Phone Number:** | | | |  | | |
| **Referral Source Email Address:** | | | |  | | |
| **Does the Individual being referred have a diagnosed behavioral health condition from a licensed professional?**  **YES  NO;** *if no, the Individual is not eligible for these housing programs* | | | | | | |
| **Has the Individual been discharged from a SUD or Inpatient care facility in the last 14 days?** Yes No  **If currently in a treatment facility, name of facility:**  **If currently in a treatment facility, expected discharge:**  **Housing plans after discharge:** | | | | | | |
| **Does the Individual meet HARPS priority population criteria as outlined  YES  NO**  *(Not eligible for Foundational Community Supports Supportive Housing Services through Medicaid, is experiencing a serious mental illness, substance use disorder or co-occurring disorder, and has been release from or at risk of entering a psychiatric inpatient setting, SUD treatment setting, homeless/at-risk of homelessness including, couch surfing)?* | | | | | | |
| **Individual Being Referred** | | | | | | |
| **Name:** | **Phone Number:** | | | | **Date of Birth:** | |
| **Social Security Number:** | **Email address:** | | | | **ICD10 (Diagnosis) Code(s):** | |
| **Gender:**  Female Male Transgender Intersex Undisclosed | | | | | | **Preferred Pronouns:** |
| **Primary Language:** | | **Interpreter required?**  Yes  No | | **Military Service:**  Yes  No Prefer not to answer | | |
| **Medical Benefit:**  Medicaid *(Provider One#):*  Medicare  Private:       Other: | | | | | | |
| **Race (check all that apply):**  White  Black/African American  Korean  American Indian/Alaskan Native Laotian  Asian Indian Native Hawaiian Cambodian  Chinese  Filipino  Japanese  Guamanian/Chamorro  Middle Eastern Other Pacific Islander Other Asian  Other Race  Not Reported/Unknown | | | | | | |
| **Hispanic Origin**:  Puerto Rican Cuban  Mexican  Hispanic – Specific Origin Unknown  Not Spanish/Hispanic  Not Spanish/Hispanic  Other Specific Hispanic | | | | | | |
| **Sexual Orientation:** Heterosexual Bisexual Gay/Lesbian Questioning Undisclosed | | | | | | |
| **Marital Status:**  Single Married Divorced Widowed | | | | **Emergency Contact:**  **Name:**  **Phone:** | | |
| **Does the Individual need any of the following supports from HARPS (check all that apply):**  Peer  Employment  Recovery  Education  Social Skills Training  Independent Living Skills  Housing  ID/Driver’s License  Community Resources  Financial  Insurance  Other: | | | | | | |
| **Is the individual currently receiving any of these services? Where?**  Case Management, agency name:       Care Coordination, agency name:  Drug Court/Family Court, agency name:      Behavioral Health Services, agency name: | | | | | | |
| **Does the Individual have any income?** Yes  No  If yes, please indicate the source       & amount $       (monthly) | | | | | | |
| **Where is the Individual currently residing/staying?** *(If inpatient, where was this individual residing prior to inpatient?)*  Emergency shelter (including hotel/motel paid for with voucher)  Place not meant for human habitation (e.g., streets, car, abandoned building, anywhere outside)    Other: | | | | | | |
| **Print name:** | | | **Signature:**       Date: | | | |