**HOUSING FOR HEALTH (HFH)**

**HOUSING AND JOBS COLLABORATIVE**

**REFERRAL FORM**

***Instructions***

To access both Housing and Jobs Collaborative and Interim Housing, please email the complete form to **Amani Taylor**, ataylor6@dhs.lacounty.gov or fax to **(213) 482-3395**. This referral form is NOT for Permanent Supportive Housing.

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referral Type (check all that apply): [ ]** Housing and Jobs Collaborative

|  |  |
| --- | --- |
| **Name of Referring Agency:** | **Staff Name/Title:** |
| **Office #:** | **Cell/Pager #:** |
| **Alternate Staff:** | **Office/Pager #:** |

|  |
| --- |
| **PARTICIPANT IDENTIFYING INFORMATION** |
| **First Name:** | **Middle Name:** | **Last Name:** |
| **Aliases:**  | **DOB:** | **Social Security #:** | **HMIS #:** |
| **Does applicant have any of the following ways of being contacted (check all that apply and specify below):** [ ]  None[ ]  Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Alternate Phone/E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Gender:**[ ] Male[ ] Female[ ] Transgender (M to F)[ ] Transgender (F to M) | **Ethnicity:**[ ]  Non-Hispanic/Non-Latino [ ]  Hispanic/Latino[ ]  Don’t Know / Decline to state | **Race:**[ ]  American Indian or Alaskan Native [ ]  Asian[ ]  Black, African/African-American [ ]  Native Hawaiian/other Pacific Islander[ ]  White [ ]  Don’t know / Decline to state |
| **Residency Status:** [ ]  US Citizen [ ]  Legal Resident [ ]  None of Above | **Primary Language:** [ ]  English [ ]  Spanish [ ]  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Can applicant communicate in English?** [ ]  Yes [ ]  No |
| **Does the applicant have the following:**Proof of legal residency: [ ]  Yes [ ]  No [ ]  Not SureCurrent ID: [ ]  Yes [ ]  No [ ]  Not SureSocial Security Card: [ ]  Yes [ ]  No [ ]  Not Sure | **Has the applicant ever served in the U.S. Armed Forces?** [ ]  Yes [ ]  No**Discharge status:** [ ]  Honorable [ ]  Dishonorable [ ]  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| **HOMELESS STATUS** |
| **Is applicant HOMELESS?** [ ]  Yes [ ]  No | **Is applicant CHRONICALLY HOMELESS (see worksheet)?** [ ]  Yes [ ]  No |
| **Current Location:** | **Length of HOMELESSNESS?** **\_\_\_\_\_\_\_\_\_\_ yr \_\_\_\_\_\_\_\_\_ mo** |
| **Specify geographical housing preference (if known):** | **VI-SPDAT score?** [ ]  Yes [ ]  No**If Yes, score(if known):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **If applicant *CANNOT* be housed in a specific geographic location, list area:** |

|  |
| --- |
| **FAMILY COMPOSITION** |
| **Marital Status:**[ ]  Single [ ]  Partnered [ ]  Married  | **Household Size (#):** | **# of adults to be housed in addition to applicant?** \_\_\_\_\_\_\_\_\_  |
| **Service Animal/Pets** |
| **Type** | **Size/Weight** | **Describe (e.g. service animal or pet, special needs required for animal, etc.)** |
|  |  |  |

**HOUSING FOR HEALTH (HFH)**

**HOUSING AND JOBS COLLABORATIVE**

**HOUSING REFERRAL FORM**

Patient First & Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN #\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **FINANCIAL** |
| **Applicant’s Income (check all that apply):** [ ]  No Income  [ ]  General Relief (GR) $\_\_\_\_\_\_\_\_\_\_\_\_/month [ ]  CalFresh (Food Stamps) $\_\_\_\_\_\_\_\_\_\_\_\_/month [ ]  Supplemental Security Income (SSI) $\_\_\_\_\_\_\_\_\_\_\_\_/month [ ]  Unemployment $\_\_\_\_\_\_\_\_\_\_\_\_/month [ ]  Social Security Disability Insurance (SSDI) $\_\_\_\_\_\_\_\_\_\_\_\_/month [ ]  Employed $\_\_\_\_\_\_\_\_\_\_\_\_/month  [ ]  Veteran’s Administration Benefits $\_\_\_\_\_\_\_\_\_\_\_\_/month [ ]  Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **EMPLOYMENT GOALS** |
| Are you interested in pursuing employment? [ ]  Yes [ ]  No  |
| What type of employment opportunities are you seeking? |

|  |
| --- |
| **EMPLOYMENT HISTORY**  |
| **Employer** | **Position/Title** | **Duration of Employment** | **Hourly Wage** | **Reason for Leaving** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |  |
| --- | --- |
| **EDUCATION AND TRAINING**  |  **LEGAL HISTORY** |
|  |  |  |  | **Has the applicant been convicted of any of the following (check all that apply):**[ ]  Arson[ ]  Production of methamphetamines[ ]  Sex offender[ ]  Violent crime (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Warrants (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **High School Diploma?** | [ ]  Yes [ ]  No | Year received:\_\_\_\_ |
| **Highest level education completed?** | [ ]  Associates [ ]  Bachelors | [ ]  Masters  [ ] Vocational  |
| **Valid ID/Driver’s License?** | [ ]  Yes [ ]  No | If no, applied?[ ]  Yes [ ]  No |
| **Are you applying for SSI?** | [ ]  Yes [ ]  No | If yes, date applied: \_\_\_\_\_ |
| **Do you owe Child Support?** | [ ]  Yes [ ]  No |  |

|  |
| --- |
| **MEDICAL INFORMATION** |
| **Health Insurance (check all that apply):**[ ] Medi-Cal [ ] Medicare [ ] Private [ ] None [ ] Unknown**Health Insurance Carrier (e.g. HealthNet/LA Care):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Primary Care Provider/Medical Home (if known):**Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Specify date of last visit (if known):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Medical Conditions (if any):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Applicant’s physical mobility/accessibility needs (check all that apply):**Mobility limitations [ ]  Yes [ ]  NoIf yes, please specify:  |

|  |
| --- |
| **MENTAL HEALTH** |
| **Cognitive Impairments (check all that apply):** [ ] None[ ] Developmental Delays [ ] Dementia [ ] Traumatic Brain Injury**Mental Health Diagnosis (check all that apply):** [ ] None [ ] Anxiety [ ] Depression [ ] Bipolar [ ] Schizophrenia [ ] Personality Disorder [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Specify behaviors related to Cognitive Impairments/Mental Health Issues:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Does applicant have a mental health provider (If Yes, specify below)?** [ ]  Yes [ ]  No [ ]  Unsure**Agency:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Contact Person/Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Patient First & Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Housing for Health Authorization to Release/Share Information**

I agree to allow the Department of Health Services (DHS) and/or HFH Service Partners (a provider that has a contract or agreement with Department of Health Services whom the department has deemed appropriate for the patient), to share my information with each other for the following purposes:

1. DHS and/or HFH Service Partners may use my information to provide me with case management, integrated and/or coordinated services, and to assist in providing temporary and/or permanent housing opportunities.
2. DHS and/or HFH Service Partners may use or disclose my information for research purposes, subject to the requirements of applicable law, and to make recommendations on policies to improve services for people experiencing homelessness.
3. I understand that if I sign this agreement, I voluntarily consent and hereby authorize DHS to release and disclose information about me to HFH Service Partners.
4. I understand that if I sign this agreement, I voluntarily consent and hereby authorize HFH Service Partners to release and disclose information about me to DHS.
5. I understand and agree that I will receive no money or other benefits from the County of Los Angeles, DHS, HFH Service Partners or any other party as a result of consenting to the release of such information.
6. I agree to release the County of Los Angeles, DHS, HFH Service Partners, its agents and employees from any liability whatsoever, including for injuries, damages and losses, known or unknown, resulting from sharing the information with other County departments, homeless service providers and housing locators, with whom the County has relationships.
7. I acknowledge that before signing this consent for release agreement, I have carefully read and fully understand its terms. If I am unable to read, the person asking me to sign this form has read and explained all of the items/terms listed in this agreement.
8. This agreement shall become effective on the date provided below and will **expire one year** from the date below.

\_\_\_\_\_\_\_\_\_\_\_\_

Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant Signature Referring Staff Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Applicant Name Print Referring Staff Name