STEADFAST HOUSING DEVELOPMENT CORPORATION

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SHDC REFERRAL FORM

☐ **SEMI-INDEPENDENT GROUP HOME/CONDO** ☐ **8-16 HOUR GROUP HOME**

☐ **24 HOUR GROUP HOME** ☐ **SUPPORTED HOUSING PROGRAM**

☐ **SUPPORTED EMPLOYMENT PROGRAM** ☐ **SHELTER PLUS CARE**

☐ **SEMI-INDEPENDENT HOMELESS FACILITY - HALE ULU PONO (KALAELOA)**

Date: _____

Name of Referral: _____

SSN: _____ **DOB:** _____

Diagnosis: _____ **Dual Diagnosed:** ☐ Yes ☐ No

CURRENT LIVING ARRANGEMENT

☐ Non-Housing (street, park, car, bus station, etc.) Specify: _____

☐ Hospital: ☐ Psychiatric ☐ Medical Specify, Name & Unit: _____

☐ Licensed Crisis Residential Shelter (LCRS) ☐ Substance Abuse Treatment Facility

☐ Transitional Housing for Homeless Persons ☐ Jail/Prison

☐ Domestic Violence situation ☐ Living with relatives/friends

☐ Rental Housing ☐ Other, Specify: _____

_____ _____

Referred By (Print Name, Title & Agency) ***Signature***

Phone No.: _____ **Fax No.:** _____

CM Name,
Agency & Ph.: _____
(if different from above)

ATTACHMENTS: ☐ SPMI Certification ☐ Homeless Certification *(if applicable)*
☐ Criminal History Certification ☐ Consent to Release Information

Copies of *Clinical History & Evaluation* are required upon acceptance of referral into SHDC programs.

FOR SHDC USE ONLY

SHDC Referral Packet Complete: ☐ Yes ☐ No

Location: _____ Move-in/Start Date: _____

Comments: _____

_____

REFERRAL RECEIVED: Date: _____ Time: _____

ASSESSMENT: Date: _____ Time: _____

☐ Clinical History & Evaluation received / requested

☐ Former tenant: Cleared for Re-admittance. _____ Authorize *(Initial)* Outstanding balance: $ _____

☐ Former tenant: Ineligible for Re-admittance. _____ Authorize *(Initial)* _____

_____