Referral Contact Information

DATE:_____/_____/_____

Agency Contact Name and Phone number: _____

Veteran's Name:_____Last Four of SS#:_____

Which program is the veteran being referred to? Select all that apply:

❑ Transitional Housing ❑ Permeant Housing ❑ HVRP/Workforce
❑ Grant Per Diem Case Management (After Care)

DOB: ___/_____/___ ETHNICITY:___ GENDER: ___

MILITARY BACKGROUND- Branch: _____ Yrs in Service: _____

Discharge Status:_____

Connected to VA: Y / N Chronic Homeless Y / N

Does the veteran currently have a case manager connected to SSVF or VASH? Y/N

If yes, how long will the case management service be for? _____ (Wks, Mnths, Yrs)

Does the veteran currently have a copy of their DD-214? Y/N (If yes, please attach)

WHERE DID CLIENT SLEEP LAST NIGHT? _____

HOW LONG HAVE THEY BEEN STAYING THERE? _____

Is the veteran currently have goals related to:

❑SUBSTANCE ABUSE HISTORY: _____

❑MEDICAL / MENTAL HISTORY: _____

❑FINANCIAL STATUS: _____

❑LEGAL STATUS: _____

What is the best way to connect to the veteran?

Phone Number:_____ and/or Email:_____