Alliance for Housing and Healing

Transitional Housing Referral

CLIENT INFORMATION

Client Name (First, Last, MI): _____

Phone: _____ Cell: _____ Alt # _____

Veteran: ☐ Yes ☐ No Victim of Domestic Violence: ☐ Yes ☐ No

CURRENT LIVING SITUATION

☐ Homeless *(Street, car park, etc.)* ☐ Emergency Shelter ☐ Transitional Living ☐ W/Friends or Family

☐ Own Home ☐ Substance Abuse Facility ☐ Rental Housing ☐ Psychiatric Facility

☐ Domestic Violence ☐ Jail/Prison ☐ Hospital/Medical

☐ Other (Specify) _____

SUPPORTIVE DOCUMENTS

The following documents should be included with this referral form:

☐ Diagnosis Form dated within the last 12 months

☐ ID

☐ Verification of Income that is dated within the last 30 days

☐ Verification of homeless status, including area where client spends most of their time

☐ Consent to Release Information, please include One Roof LA, LLC

REFERRING PROVIDER

Referring Agency: _____ Referring Provider Name: _____

Phone: _____ Email Address: _____

_____ _____

Referring Provider Signature Date