**Mikinaak Ode Shelter Referral Form**

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| **BASIC INFORMATION** |

**First Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **M.I.** \_\_ **Last Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ **Income:** $\_\_\_\_\_\_ /month

**1. Current household status:**

☐ Single Adult ☐ Multiple Adults ☐ Adult(s) with Minor Children ☐ Youth 16-24 years old Number of Household Members: \_\_\_\_\_

**2. Observations that might be helpful to know about the person/family being referred (Optional)** Description of Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Special Needs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: (Include comments such as preferred language, physical disabilities, gender, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **HISTORY OF HOUSING AND HOMELESSNESS** |

**3. Most frequently used place to sleep:**

☐ Outdoors ☐ Car / RV ☐ Shelters/Transitional Housing ☐ Motels / Hotels ☐ Doesn’t Know ☐ Refused ☐ Other (Specify):

**4. Number of months since the homeless individual/family lived in permanent stable housing:** \_\_\_\_\_ Months ☐ doesn’t Know ☐ Refused

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| **VETERANS**  |

**5. Service in the U.S. Military (Veteran):**

☐ Yes ☐ No ☐ Doesn’t Know ☐ Refused

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| **FOLLOW-UP QUESTIONS** |

**6. Phone number, email address, and/or location that the service provider can use to contact the homeless individual/family:**

Phone #: \_\_\_\_\_\_\_\_. Best Time to Reach: \_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**7. City/region/intersection the homeless individual/family most identifies as their community. (Note: This response will determine which CES region receives the referral.):**

Location: SPA #:

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| **AUTHORIZATION** |

**For in-person referrals:** *By signing this form, I am permitting it to be sent to a Coordinated Entry System- provider in my area so that they can contact me*.

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

Signature Date

**For telephonic referrals:**

*Check if client permitted you to send this to a Coordinated Entry System provider in his/her area so that they can contact him/her.* Initials: \_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_ 

**Referring County Dept.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of referring person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel # (\_\_\_\_ \_) \_\_ \_ \_\_-\_\_\_ \_\_\_\_\_ Date of Referral \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_**