HOUSING SERVICES
REFERRAL FORM

Date of Referral: _____

Head of Household Name: _____ Age/DOB: _____ Gender: F or M

Number of household members (and ages): _____ children _____adults

Head of Household Contact Information: _____

Mailing address: _____

Referral Source/Agency: _____

Phone number/email address: _____

Reason for Referral:

☐ Screening for Family Supportive Housing Program/Youth Homelessness Demo Project/Housing Navigation

☐ Other:

_____

Homelessness

Families must be currently homeless per HUD definition.

Please describe the family's current housing situation.

_____
_____
_____
_____

History of Domestic Violence? (Past or Current) Y ☐ N ☐

_____
_____

Active Department of Corrections Case: Y ☐ N ☐ (please indicate which household member, probation or parole, and underlying sentence?)

_____
_____

Active DCF- Economic Services Case: Y ☐ N ☐ (Food Stamps, Health Care, Reach Up, General Assistance?)_____
_____

Active DCF- Family Services Case: Y ☐ N ☐ (CHINS, YIT, Child who has aged out of system)

_____
_____
_____

Active DCF- Office of Child support case? Y ☐ N ☐ Either as Non-Custodial Parent (NCP) or Custodial Parent (CP) _____

_____

Active Vt. Department of Health Case: Y ☐ N ☐ (WIC, Healthy Babies, etc.)

_____
_____

History of Substance Abuse: Y ☐ N ☐ (Intensive Outpatient, Turning Point, AA/NA, BAART, other substance abuse services?)

_____
_____

Active Washington County Mental Health Case: Y ☐ N ☐ (CRT, Developmental Disabilities, or has Case Manager and services)

_____
_____

  ➢ Not Active, but has Mental Health issues or Developmental Disabilities (Past or Current, Self-Disclosed) if known please explain: Y ☐ N ☐ _____
_____

Referral Details

Please provide any additional information that would be helpful regarding this individual/family:

_____
_____
_____

Family Supports
Please fill in those who are a support to this family

Reach Up   Contact Name and Information: _____
Community Health Team Contact Name and Information: _____
Voc-Rehab   Contact Name and Information: _____
Community Action   Contact Name and Information: _____
Parent-Child Center   Contact Name and Information: _____
Circle   Contact Name and Information: _____
WCMHS   Contact Name and Information: _____
Turning Point Center   Contact Name and Information: _____
Probation and Parole   Contact Name and Information: _____
CIS   Contact Name and Information: _____
Adult Basic Education   Contact Name and Information: _____
Other: _____

This form must be sent to: housingreferrals@fcwcvt.org
Fax 802-262-6071
For questions, you may contact us at (802) 262-3292 x135

_____
FCWC USE ONLY
 Received: _____Assigned to: _____ Disposition: _____