



Eagle Star Housing Referral Form

Permanent Supportive Housing

Helping Homeless Veterans since 2012

Resident Name/s: _____ Referral Date: _____
Resident Phone #: _____ Date of birth: _____
Email: _____ Gender Identity: _____

Current Address: _____
Current Living Situation: Shelter Homeless At Risk of homelessness Unstably Housed

Social Security #: _____ Medicaid #: _____
Dates of Military Service: _____ Military Discharge Status: _____

Emergency Contact: _____ Relationship: _____
Phone #: _____ Email: _____
Does the prospective resident have any therapy animals? Yes No
~ If yes, does the prospective resident have any documentation for the animal? Yes No

Referral Agency: _____ Referred by: _____
Phone #: _____ Email: _____

Eligibility Determination: *Service eligibility includes any person who has served in the Military, is considered homeless or unstably housed and requires assistance with activities of daily living.*

Which category of organization is making the referral?
Shelter Hospital SPOA Continuum of Care
Medical Respite DSS Skilled Nursing Facility Veterans Organization

Are VA services received? Yes No – If no, are they eligible? Yes No

With which home management activities does the person need assistance?

Please describe current situation and what led to the need for assistance?



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Medical Doctor Name:

Other Clinical/Medical Provider Name:

Agency: _____

Agency: _____

Phone #: _____

Phone #: _____

Other Clinical/Medical Provider Name:

Other Clinical/Medical Provider Name:

Agency: _____

Agency: _____

Phone #: _____

Phone #: _____

Risks (please check all that apply and note date of occurrence if appropriate - state NA if not applicable):

Engaged in arson (date: _____)

Destruction of property (date: _____)

Sexual offenses toward others (date: _____)

Violent criminal offenses toward others or property (date: _____)

Physical harm to others (date: _____)

Suicide attempt/self-injury (date: _____)

Victim of physical or sexual abuse (date: _____)

Other previous or current legal involvement:

Medical Issues (please check all that apply):

History of falls

Incontinence

Hearing loss

Vision loss

Impaired ability to walk?

Yes

No

~ If yes, the resident uses a (please check all that apply):

Walker

Wheelchair

Transfer Chair

Medical Concerns/Comments/Other Information:



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Mental Health Diagnoses (be specific to include Axis 2 Diagnoses): _

Substance Abuse Diagnoses and frequency of use (be specific):

Please complete the following - responses should be 'No Assistance Required' or 'Assistance Needed'::

Manage their personal care needs (grooming, hygiene, laundry, cleaning, etc):

Use their own transportation, public transportation, and other community resources:

Respond appropriately to emergency situations (i.e medical, fire):

Follow through with appointments and other responsibilities:

Plan, shop and prepare meals:

Manage their own money:

Please describe the resident's previous:

Independent living experience:

Drug/alcohol treatment history:

Interpersonal skills/supports (including family):

Hospitalizations (causes and dates): _



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Does the resident comply with their medication regime?		Yes	No		
~Is resident self-medicating?	Yes	No	~ If no, are supports in place to assist	Yes	No
~Filling their own prescriptions?	Yes	No	~ If no, are supports in place to assist	Yes	No

Funding (please check all sources of income recipient currently receives):

SSI - \$ _____ per month	Alimony - \$ _____ per month
SSD - \$ _____ per month	Employment - \$ _____ per month
SSP - \$ _____ per month	Pension - \$ _____ per month
DHS - \$ _____ per month	Trust Fund - \$ _____ per month
SNAP Benefits - \$ _____ per month	Other - \$ _____ per month

Assets (please list all assets):

Debts (please list all debts, including past utilities, child support, credit card debt, etc):

Does the resident have:

~ Medicare?	Yes	No	- If yes, Medicare #: _____
~ Medicaid?	Yes	No	- If yes, Medicaid #: _____
~ Private Insurance?	Yes	No	- If yes, plan and #: _____
~ Representative Payee?	Yes	No	- If yes, agency: _____

Required Documents (please **check** all documents in resident possession):

- | | |
|------------------------------|-----------------------------------|
| DD-214 | Bank Statements |
| Social Security Card | Previous Year Tax Returns or 1099 |
| Birth Certificate | Pay Stubs |
| Photo Identification | Alimony/Child Support Documents |
| Social Security Award Letter | Proof of Assets or Mortgage |



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** Please provide the most recent psychosocial evaluation, psychiatric assessment, or needs assessment as indicated and any other assessments that may be helpful. This will expedite the referral process.

Signature below indicates this potential resident is medically and psychiatrically stabilized, does not need a higher level of care and is considered appropriate for the Veteran Supportive Housing Program. To the best of my knowledge, the potential resident meets the eligibility criteria listed above.

Signature of Referral Agent: _____ **Date:** _____
(required)

Print name and title: _____

Signature of Resident: _____ **Date:** _____
(required)

Print name: _____

Completed referrals for 270 on East can be submitted to:

Elizabeth Doll, LCSW-R - House Administrator
Eagle Star Housing

edoll@eaglestarhousing.com

585-704-3067

Completed referrals for Liberty Square can be submitted to:

Sarah-Catherine Sargeant-Program Manager
Eagle Star Housing

ssargeant@eaglestarhousing.com

585-815-3498

Completed referrals for Huntington Apartments can be submitted to:

Jessica Belle, LCSW- Program Manager
Eagle Star Housing

jbelle@eaglestarhousing.com

585-667-1070