Eagle Star Housing Referral Form

Supportive Housing for Veterans

Helping homeless Veterans in upstate New York since 2012

Resident Name: ______________________________ 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:

____

Agency: ______________________________

Phone #: _____________________________

Other Clinical/Medical Provider Name:

____

Agency: ______________________________

Phone #: _____________________________

Other Clinical/Medical Provider Name:

____

Agency: ______________________________

Phone #: _____________________________

Other Clinical/Medical Provider Name:

____

Agency: ______________________________

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:

____

____

____

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

SSD - $_________ per month

SSP - $_________ per month

DHS - $ ________ per month

SNAP Benefits - $ ________ per month

Alimony - $________________per month

Employment - $____________ per month

Pension - $ _______________ per month

Trust Fund - $ _____________ 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

Social Security Card

Birth Certificate

Photo Identification

Social Security Award Letter

Bank Statements

Previous Year Tax Returns or 1099

Pay Stubs

Alimony/Child Support Documents

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 can be submitted to:
Michelle Laraby, LCSW - House Administrator
Eagle Star Housing
mlaraby@eaglestarhousing.com
585-667-1284