EAGLE STAR HOUSING

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:

_____

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:

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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

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 for 270 on East can be submitted to:

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

edoll@eaglestarhousing.com

585-704-3067
585-488-0006 (Fax)

Completed referrals for Liberty Square can be submitted to:

Michelle Laraby, LCSW - House Administrator
Eagle Star Housing

mlaraby@eaglestarhousing.com

585-667-1284
585-483-3455 (Fax)