REFERRAL FOR HOUSING

Date of Referral _____

Name _____ **Telephone:** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Social Security # _____ **Date of Birth** _____

Source & Amount of Income _____

Referral Source _____

Address: _____ Phone: _____

Referral is a Client of:

_____Carey Counseling Center Client # _____

_____Professional Counseling Center Client # _____

_____Quinco Mental Health Center Client # _____

_____ Other _____

Type of Housing Required:

Diagnosis: _____

_____ Congregate ILF

C.M. Name: _____

_____ Agency Operated Group Home
_____ Independent Apartment

Area Requested _____

Date Placed in Housing _____

Need to Coordinate with MH/SA Agencies? _____ Yes _____ No

If Yes, Name of Agency _____