MIAMI DADE COUNTY HOMELESS TRUST

AGENCY HOUSING/ SERVICE REFERRAL FORM FOR EMPLOYEES OF HOMELESS TRUST FUNDED PROGRAMS

INSTRUCTIONS: Agency making referral must complete this two-page form, including signatures by Applicant and Agency Representatives. Fax completed forms to Agency Receiving Referral for Housing and or Services.

Date:_____ Referring Agency:_____

Contact Person:_____
Name Title Phone Number

INFORMATION ON HEAD OF HOUSEHOLD:

Last Name:_____ First Name: _____

Date of Birth:_____ SS #:_____

INFORMATION ON OTHER HOUSEHOLD MEMBERS:

Name	Age	Sex	Relationship	Employer

IS ANY MEMBER OF THE HOUSEHOLD EMPLOYED BY, OR RELATED TO AN EMPLOYEE OF, A HOMELESS TRUST FUNDED PROGRAM? Yes____ No_____
If yes:

Name of Employee:_____

Employing Agency:_____

Relationship to Applicant: _____

CERTIFICATION

I, the undersigned, do hereby certify that the above information provided by me is true and correct to the best of my knowledge.

Applicant's Name_____

Signature: _____ Date: _____

Referring Agency Authorized Representative

Name:_____Signature_____Date_____

AGENCY REFERRAL FORM PAGE TWO

Applicant's Name_____

If the Applicant or a member of their household is an employee of the referring agency, the approval of the Agency Executive Director is hereby indicated by signature:

_____ _____
Name/Title Date

If the Applicant or a member of their household is an employee of the agency where services will be provided, **the approval of The Agency Executive Director, the Homeless Trust Executive Director, and the Homeless Trust Board Chair are hereby indicated by signature:**

_____ _____
Agency Executive Director Date

_____ _____
Miami-Dade County Homeless Trust Chairperson Date

_____ _____
Miami-Dade County Homeless Trust Executive Director Date

ADDITIONAL HOUSEHOLD INFORMATION:

Where is the household living now? (Facility name, exact address)_____
_____

Date of present homelessness:_____

Explain the homeless situation, and what caused the current homelessness:_____
_____
_____

NOTE TO REFERRING AGENCY:

PROVIDING THE ABOVE INFORMATION DOES NOT ENSURE APPROVAL FOR HOUSING OR OTHER SERVICES REQUESTED. A DETERMINATION WILL BE MADE FOLLOWING A COMPLETE ASSESSMENT OF THE APPLICANT'S CASE.

THIS SECTION FOR SERVICE PROVIDER STAFF USE:

Meets Eligibility Criteria: ____ YES ____ NO

Name of Provider Screening Staff: _____

PLEASE MAINTAIN THE EXECUTED COPY OF THIS DOCUMENT IN THE CLIENT FILE OF THE SERVICING AGENCY AND PERSONNEL FILE OF REFERRING AGENCY.