FamilyPromise
of Sussex County

Permanent Supportive Housing for the Chronically Homeless

Referral Check List

Referral For (Please check one):		
☐ Hunterdon County Resident	☐ Sussex County Resident	☐ Warren County Resident

Date of Referral: _____

Client Name: _____

Attached is the completed Referral packet for Permanent Supportive Housing for the Chronically Homeless. Included with this referral the following documents

- ☐ Photo identification for all household members
- ☐ Documentation of homelessness
- ☐ Documentation of Disability Form
- ☐ Income verification for all household members age 18 and older
- ☐ Copy of birth certificate for all members of household
- ☐ Social Security cards for all members of household
- ☐ Signed authorizations for the release of information from all pertinent providers

This documentation is to be used for an initial screening in consideration for application to the permanent housing program. If considered, I agree to work with the applicant to submit a full completed application to the housing program.

Referring individual name and agency: _____

_____ _____

(Signature) (Date)

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Referral Form

Referral For (Please check one):

☐ Hunterdon County Resident ☐ Sussex County Resident ☐ Warren County Resident

Date of Referral: _____

Referring Agency (name and address): _____

_____

Contact person: _____ Contact number: _____

Email: _____

Reason for Referral: _____

_____

Name of person being referred: _____

Last Permanent Address: _____

Current Address: _____

Phone number for person being referred: _____

Date of Birth: _____ Primary Language: _____

Social Security # _____ Marital Status: _____

Emergency contact person & relationship: _____

Emergency contact phone number: _____

Disabling Condition: _____

Other mental and physical health concerns: _____

_____

_____

Current medications: _____

_____

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Certification of Disability

Name & Address: _____

Date of Birth: _____ Social Security # _____

The above referenced individual is a member of a household that has applied to participate in a federally funded housing program administered by Family Promise of Sussex County. Certification of disibility is required to determine eligibility for the program. A person with disability, as defined by the US Department of Housing and Urban Development:

"Any person who has a physical or mental impairment that substantially limits one or more major life activities; has a record of such impairment; or is regarded as having such an impairment."

Please check the appropriate box:

☐ *The person is disabled and receiving Social Security for the disability (attach a copy of the SSA award letter)*

☐ *The person has a physical, mental, or emotional impairment (including substance use disorder) that is expected to be of a long and indefinite duration, substantially impedes his or her ability to live independently, and is of such a nature that ability to live independently could be improved by more stable housing conditions*

☐ *The person has a developmental disability, which is a severe and chronic disability that is 1) attributed to a mental or physical impairment or combination of impairments; 2) is likely to continue indefinitely; 3) results in substantial functional limitations of major life activities*

Describe disability: _____

_____

_____

In my professional opinion, I certify that the information listed above is true and correct to the best of my knowledge.

_____
Print name of Licensed Professional

_____
Signature of Licensed Professional Date

Professional Qualifications:

___ LCSW ___ Psychiatrist

___ LPC ___ Psychologist

___ Physician ___ Clinical Nurse Specialist

License # _____

This form is invalid without applicable license number

Family Promise of Sussex County P.O. Box 154, Newton, NJ 07860 973-579-1180 info@familypromisesussex.org

Psychiatric hospitalizations:

Institution Name and Address (most recent)	Admission Date	Discharge Date

Other hospitalizations:

Institution Name and Address (most recent)	Condition	Admission Date	Discharge Date

History of Drug and Alcohol Use:

Last use date: _____

Substances used: _____

History of suicidal ideation, plans, attempts (please include dates and details): _____

_____

_____

_____

History of aggressive behaviors (please include dates and details): _____

_____

_____

_____

Pending legal charges (please provide details): _____

_____

Medical Conditions (if applicable):

Diagnosis:	Date Diagnosed:
Treating Physician:	Treating Physician Phone:
Treating Physician Address:	
Diagnosis:	Date Diagnosed:
Treating Physician:	Treating Physician Phone:
Treating Physician Address:	
Diagnosis:	Date Diagnosed:
Treating Physician:	Treating Physician Phone:
Treating Physician Address:	

Is referral person currently on KROL status (found not guilty of criminal charges due to a mental illness)? _____

Allergies: _____

_____

Resource currently in place for referral (please list amounts if known):

- SSI $ _____
- SSD $ _____
- SSA $ _____
- TANF $ _____
- VA $ _____

Does Referral currently receive:

Rental Assistance: $ _____ Agency: _____

- General Assistance $ _____ County: _____

Other $ _____ Describe: _____

Are there any special accommodations required to meet the needs of the referral? Yes or No

If yes, please explain: _____

Referring individual name and agency: _____

_____ _____

(Signature) (Date)