Wait List Referral Form

Form should be completed by authorized referral source and sent electronically or faxed to:

All Single Adult Programs: Robin Chambers, *rchambers@carrfour.org* or 305-756-2742 (f)
All Family Programs: Francesca Steele, *fsteele@carrfour.org* or 305-513-5176 (f)

*** Incomplete referral forms will be returned.***

Date of Referral: ____

	First Name	Last Name	Gender	D.O.B.	Place of Birth	Relationship to HOH	Last 4 Digits of SSN	HMIS Number (If applicable)
1						HOH		
2								
3								
4								
5								
6								
7								
8								

1. Applicant's (HOH) Phone Number: ______________________ Alternate Phone Number: ______________________
2. Applicant's Email Address: ____
3. Employed? Y or N
4. Receiving monetary benefits (SSI/SSDI, TANF, etc.)? Y or N Total Monthly Household Income:$ __________
5. Has applicant been homeless or in shelter 4+ times in the last 3 years? Y or N
6. Is applicant a veteran? Y or N
7. Current Living Situation (Check *one*)
   - ❑ Street or other location not meant for human habitation
   - ❑ Shelter, Name of Shelter ______________________________________
   - ❑ Transitional Housing (for homeless persons who originally came from streets or emergency shelter), Name of Program ______________________________
   - ❑ Other, ____

*** *HUD funding requires that applicant meet specific living situations in order to be considered eligible for programs.****

8. Does the Head of Household qualify as having a disability that is expected to be of long-continued and indefinite duration, a developmental disability, or substance abuse, a disease of acquired immunodeficiency syndrome (AIDS) or conditions arising from the etiologic agency for acquired immunodeficiency syndrome. Y or N
9. Is the Head of Household receiving (or pending) SSI or SSDI benefits? Y or N
10. Does a child in the household qualify as having a disability that is expected to be of long-continued and indefinite duration, a developmental disability or a disease of acquired immunodeficiency syndrome (AIDS) or conditions arising from the etiologic agency for acquired immunodeficiency syndrome ***and*** receiving SSI or SSDI benefits? Y or N

Attach business card of referring professional

A copy of a business card *must* be submitted with this application.

My signature below indicates that the above information is accurate.

Authorized Referral Signature:

____

Print Name:______________________________

Phone Number:___________________________

Email:__________________________________

Date: __________________________________