SIMCOE COUNTY REGIONAL
HOUSING FIRST
PROGRAM

Coordinated Intake Referral Form

Eligibility Considerations:

Simcoe County Regional Housing First Program is for those who have a history of chronic homelessness, score "high" on the SPDAT, and provide consent to be placed on the Prioritization List.

Participant Information	
Intake Date:	**New Referral:** ☐ **YES** ☐ **NO**
Participant's Name:	**D.O.B.:**
Gender Identity:	**Age:**
Co-Participant's Name:	**D.O.B.:**
Gender Identity:	**Age:**
An explanation of the Housing First Program has been provided to the participant: **(Date)_____**	
An explanation of the Intake Process has been provided to the participant: **(Date)_____**	
VI-SPDAT been completed? ☐ **Yes** **Date: _____** ☐ **No** **Version: _____** **Score:_____**	**Name and Contact Information for person who administered the VI-SPDAT or Full SPDAT (if different from person submitting form)**
SPDAT completed: ☐ **Yes** **Date:_____** **Version:_____** **Score:_____** ☐ **No** **Check if support required to complete SPDAT** ☐ ☐ **Check if moderate Case Management support is required**	

Participant's Contact Information	
Telephone Number:	**Text Only:** ☐ **YES** ☐ **NO**

	Pays for Incoming Calls: ☐ **YES** ☐ **NO** **Specific Hours of Contact:** ☐ **YES** ☐ **NO** **Specify Contact Hours:** _____
Email Address:	**If no contact method available, where does the participant spend most of his/her time:** _____ **Is there someone else we can pass messages through:** ☐ **YES:** _____ ☐ **NO**

Referring Information

Agency/Program: _____

Referring Staff: _____

Phone Number(s): Office_____ **Cell:** _____

Email Address: _____

Region of Referral:

How long have you known the participant: (length of time involved with referring agency)

Reason for Referral (Short Narrative):

Plan to continue involvement with participant ☐ **Yes** **or** ☐ **No**

Current Services:

Situational Information

☐ **Chronically Homeless** ☐ **Frequent Shelter**

Current Sleeping Situation:

☐ **Emergency Shelter** ☐ **Outside** ☐ **Hospital** ☐ **Correctional Institute** ☐ **Couch Surfing**

☐ Child Protective Services ☐ Other:_____

Previous Sleeping Situation:

☐ Emergency Shelter ☐ Outside ☐ Hospital ☐ Correctional Institute ☐ Couch Surfing

☐ Child Protective Services ☐ Other:_____

Does the participant have a source of Income: ☐ YES (Source)_____
☐ NO

Does the participant have a trustee: ☐ YES (Contact Information) _____
☐ NO

Information that will help remove any barriers to finding/keeping housing:

Consent

Please have the individual being referred sign below indicating consent for referral.

_____ _____

Participant's Signature Date

_____ _____

Co-Participant's Signature Date

_____ _____

Referring Agency Staff's Signature Referring Agency Supervisor Signature