## Supportive Services for Veteran Families Program

## Referral Form

## (To be completed by referring Provider Staff or Veteran Self-Referrals)

Veteran Singles and Families may be referred to this SSVFP from housing and sheltered and unsheltered homeless programs. Referring staff will need to participate in the referral process and provide full information/verification as needed. Thank you for your help.

Client Name (Client Name	DOB _	Gender _	HMIS #	
Single Family (C	neck). Family Composition	: # of Adults	_ # of Children	
1. Please indicate current location	a & telephone contact informa	ition of Veteran/Fami	ly:	
2. How long have you worked wi	th this individual?	In what capac	ity/position/ program?	
3. Why do you believe this individual	dual is appropriate for this pro	 ogram?	·	
4. The client must provide house	hold, household income and a	usset, and housing info	rmation with verification.	
Does the client understand this?	$\underline{Y / N}$ . [SSVF eligibility requ	iires household incom	e at 50% or less AMI.]	
5. The client must prove their sta	tus as a Veteran with other th	an dishonorable disch	arge. Can the client produce	
their DD Form 214? $\underline{Y / N}$ .				
6. The client will need to be able	to verify their Housing Status	with current housing	information, or homelessness	
with previous housing and/or pla	nned housing information, in	cluding leases, utility is	nvoices and payments, etc.	
Does the client understand this?	$\underline{Y/N}$ . [Homeless clients mu	ist have left permanen	t housing within last 90 days.]	
7. What behaviors has the client	demonstrated in the past that	may inhibit their succ	ess?	
Please indicate any other needs o	r comments:			
As the referring staff, I agree to mainted him/her fully transition to the SSVF.				
Referring Staff Name Referring Agency:	Signature	Phone:	Date	
Address:		Email:		