A Way Home for Tulsa
Tulsa City/County Continuum of Care

Referral Form

VI SPDAT Score: ____

Referral Information

Date: _____
Preparer: _____
Contact Person, if different: _____ Phone: _____
Agency: _____ Phone: _____
Address: _____ City/State/Zip: _____

Client Information

Applicant name: _____ DOB: _____
Address: _____ City/State/Zip: _____
Mailing address, if different: _____
Current living arrangements: _____
Phone: _____ Alternate phone/Message phone: _____
Gender: _____ SS#: _____ Veteran: ☐Y ☐N Race: _____
Marital status: _____ Last grade of school completed: _____
Pregnant: ☐Y ☐N If yes, # of months: _____ Currently enrolled in school: ☐Y ☐N

Emergency contact: _____ Phone: _____
Relationship: _____
Address: _____ City/State/Zip: _____

Income/Benefit Information

Monthly income sources & amount: SSI: $ _____ SSDI: $ _____
SS Retirement: $ _____ SS Survivors: $ _____ SSA claim drawn under SSN: _____
Belonging to: ☐Father ☐Mother ☐Spouse ☐Other: _____
Employment: $ _____ Pension: $ _____ Long/Short term disability: $ _____
Unemployment: $ _____ VA: $ _____ TANF: $ _____ SNAP: $ _____
Other DHS: $ _____
Insurance: ☐Medicare ☐Medicaid/Soonercare ☐Private: _____
If in application for benefits, which: _____

Employer if applicable: _____ Contact name: _____
Address: _____ City/State/Zip: _____

Payee name if applicable: _____
Relationship/Agency: _____ Phone: _____
Address: _____ City/State/Zip: _____

Household Members

Name: _____ Relationship: _____ DOB: _____

Name: _____ Relationship: _____ DOB: _____

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Name: _____ Relationship: _____ DOB: _____

Monthly income by Household Members:

Source _____ $: _____ Earner: _____

Source _____ $: _____ Earner: _____

Source _____ $: _____ Earner: _____

Medical Information

MENTAL HEALTH DIAGNOSIS: ☐ Per client ☐ Per agency: _____

Diagnosis: _____

_____

Most recent mental health provider agency: _____

Currently engaged in treatment with agency: ☐ Y ☐ N

Case Manager: _____ Therapist: _____

Doctor: _____ Day treatment: _____

GENERAL HEALTH DIAGNOSIS: ☐ Per client ☐ Per agency: _____

Diagnosis: _____

_____

Most recent general health provider: _____

Currently engaged in treatment with agency: ☐ Y ☐ N

Doctor: _____ Clinic: _____

Current medications: _____

_____

_____

_____

Medication compliant: ☐ Y ☐ N

Hospitalizations related to psychiatric, drug and alcohol treatment:

Facility: _____ Dates: _____

Reason for admission: _____

Facility: _____ Dates: _____

Reason for admission: _____

Facility: _____ Dates: _____

Reason for admission: _____

Historical Information

Suicidal: ☐Y ☐N History of self mutilation: ☐Y ☐N Problem with stairs: ☐Y ☐N

History of DV/abuse: ☐Y ☐N If yes, how many months ago and if still fleeing: _____ ☐Y ☐N

History of explosive or volitile behaviors: ☐Y ☐N If yes, how many months ago: _____

Frequency: _____

Specify behaviors: _____

Drug(s) of choice, frequency(s) of use and how recent for each: _____

_____

_____

_____

Currently in a recovery program of any kind: ☐Y ☐N

Name of program(s): _____

Interested in sobriety: ☐Y ☐N

Any legal issues, court involvement, evictions and/or incarcerations in past year: ☐Y ☐N

If yes, explain: _____

_____

_____

Include the Following Documents with this Form

☐HUD Chronic Homelessness Form

☐HUD Disability Form

Applicant/Client Signature: _____ Date: _____

Preparer signature: _____ Date: _____

Preparer is Applicant's Case Manager: ☐Y ☐N (Case Manager required for VOA applications)

Housing Staff Only

For VOA Staff

Date application received: _____ Accepted: ☐ Y ☐ N Applicant notified: _____

Tulsa Day Center for the Homeless

Date application received: _____ Received by: _____

Date application reviewed: _____ Reviewed by: _____

For MHAOK Staff

Reviewed by staff performing intake: _____

Signature of staff: _____ Date: _____

Form/Attachment A
2/2015

HUD DISABILITY DOCUMENTATION

Disability Documentation for: _____
Print Name Here

The person listed above has been diagnosed by our program with the following disabling condition(s). Check all that apply.

- ☐ Serious Mental Illness
- ☐ Substance use disorder
- ☐ Chronic physical illness/disability
- ☐ Developmental disability
- ☐ HIV/AIDS

The diagnosis is:

Approximate date of on-set of disability: _____
Month/Year

Date of last diagnosis: _____
Month/Year

x _____
Signature of Qualified Person

x _____
Title

x _____
Date

This form must be printed on Agency letterhead and signed by a qualified person:
LADC, LBP, LPC, LCSW, LMFT, PhD, MD or DO.

HUD CHRONIC HOMELESS DOCUMENTATION

Staff Name _____; **Phone** _____

Agency _____; **e-mail address** _____

Chronic Homeless Documentation for: _____

Does the participant have a disability? Yes ☐ No ☐

If "Yes", please describe: _____

In the space below, please provide a brief but detailed history of the participant's living situation over the past three years. Note: You must provide month(s), year and place. Please begin with the participant's current living situation and work your way back.

From (Ex: Jan. 2014)	To (Ex: today's date)	Place (Ex: Staying under US Hgwy 75 bridge on Katy Trail behind the jail)

_____; _____

Signature and Title **Date**

By signing this document, I understand under penalty of perjury that all information is true and correct to the best of my knowledge. I am aware that any funds provided to the person listed above are federal in nature and therefore subject to HUD regulations. Thus, any inaccuracies known by me, whether by omission or commission, may be prosecuted as a FEDERAL OFFENSE including FEDERAL FELONY.

This form must be printed on your agency's letterhead and signed and dated.