SIMCOE COUNTY REGIONAL HOUSING FIRST PROGRAM

Prioritization Table Use
File #: _____
Assigned To: _____
Date Assigned: _____
☐ RRH ☐ HF

Coordinated Intake Referral Form

Forward completed forms by email to housingfirstreferral@empowersimcoe.ca, or by fax to 705-726-6875

History of Homelessness

☐ Currently Experiencing Homelessness ☐ Chronically Homeless ☐ Episodically Homeless ☐ Frequent Shelter ☐ Motel Voucher System

☐ LGBTQ2S ☐ Indigenous (specify): _____ ☐ Domestic Violence ☐ Youth 16yrs – 24yrs ☐ Human Trafficking

Include number of years homeless, amount of time in shelter within the past year, length of unsheltered homelessness, length of couch-surfing, if a family – together or separate:

Current Sleeping Situation:

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

☐ Child Protective Services ☐ Mental Health Facility ☐ Other:_____

Previous Sleeping Situation:

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

☐ Child Protective Services ☐ Mental Health Facility ☐ Other:_____

Participant Information

Intake Date:	**Previous Housing First Participant?** ☐ YES ☐ NO
Participant's Name:	**D.O.B.:**
Gender Identity:	**Age:**
Co-Participant / Spouse Name:	**D.O.B.:**
Gender Identity:	**Age:**

Dependents		If Child in Custody
Name:	**D.O.B.:**	**School:**

Name:	**D.O.B.:**	**School:**
Name:	**D.O.B.:**	**School:**
Name:	**D.O.B.:**	**School:**
Name:	**D.O.B.:**	**School:**

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: _____**

SPDAT **Date:_____ Version:_____ Score:_____**	**Name and Contact Information for person who administered the Full SPDAT (if different from person submitting form)**

Housing Considerations

Housing Type Preferred:

Housing Size Required:

Preferred Location Within City/Town:

Accessibility Considerations:

Specific Support Considerations:

Barriers to Housing:

Participant's Contact Information

Telephone Number:

Email Address:	**If no contact method available, 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** ☐ **No**

Current Services:

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**