Support. Hope. Thrive.

SUPPORTIVE ADDICTION AND MENTAL HEALTH HOUSING TRANSITIONAL HOUSING COMMUNITY PARTNER REFERRAL

PROTECTED B WHEN COMPLETE

Client Name:	Primary Contact information (phone/email):
Best way to reach client:	
Date of Birth:	
Name and contact info of referring worker:	
Community service provider involvement	List all providers involved and their role: 1. 2. 3.
Is this client interested in abstinence based Transitional Housing and the requirements of meeting regularly with support staff?	☐ Yes ☐ No ☐ Unknown
Current Housing Situation: ☐ Homeless ☐ Precariously Housed ☐ Housed ☐ Incarcerated	Please describe:
Mental Health and Justice Involvement Yes No	Please describe:
Substance use treatment history: *Must be within the last 12 months*	Please describe:
Funding source:	Please describe:

SAMH USE ONLY: SCREENING OUTCOME
☐ Eligible ☐ Ineligible Please specify:

PLEASE FAX COMPLETED FORM TO SAMH HOUSING AT : 519-837-8035