Ryan White Part A/HOPWA-STRMU

Housing Referral Form

Complete all sections of the referral form and send it via secure email to columbushousing@equitashealth.com, along with the client's most recent Columbus Public Health Part A Eligibility Form and Housing Network Release Form. Incomplete forms may be returned to the referral source.

Date: _____/_____/_____

Referral Source Information

Name of Professional: _____ **Agency Name:** _____

Phone Number: (_____) _____ **E-mail Address:** _____

Would you like to attend the intake meeting with the housing case manager and client? Select Yes or No

If NO: **Are there any concerns about the housing case manager meeting one-on-one with the client?** Select Yes or No

If YES: **Please explain:** _____

By signing this form, I verify that all client eligibility information has been properly reviewed and documented per Columbus Public Health policy and that the client is approved to access Columbus Ryan White Part A services.

Signature of Referring Professional *(required)*: _____

Client's Ryan White Part A Eligibility Expiration Date: _____/_____/_____

Central Ohio HIV Case Management Network Release Expiration Date: _____/_____/_____

Client Contact Information

First Name: _____ **Last Name:** _____

Preferred Name: _____ **Date of Birth:** _____/_____/_____

Gender Identity: ☐ Male ☐ Female ☐ Transgender (MTF) ☐ Transgender (FTM)

Home Address *(including city, state, and zip code)*: _____

Phone Number: (_____) _____ **E-mail Address:** _____

Preferred Method(s) of Contact *(check all that apply)*: ☐ Mail ☐ Phone ☐ E-mail

May confidential messages be left on voicemail? Select One

Client Housing Information

1. Monthly Income: $_____

2. Source of Income *(e.g. SSI, SSDI, employment)*: _____

If the client has no source of income:

3. Is there a plan to gain income, e.g. employment, application for benefits? Select Yes or No

If YES: **3a. Provide a brief description of the status of the plan:** _____

4. What is the client's current living situation? Select One

If OTHER: **4a. Indicate the client's living situation:** _____

5. What is the total number of individuals in the household? _____

6. Does the client receive a housing subsidy and/or other form of financial assistance to pay rent? Select One

If YES: **6a. What assistance does the client receive?** *(check all that apply)*

☐ Section 8 ☐ HOPWA ☐ FEMA ☐ Other: _____

7. Does the client have, or at risk of receiving, an eviction notice? Select One

8. Does the client have, or at risk of receiving, a utility disconnection notice? Select One

Request Information

9. What assistance does the client need? *(check all that apply)*

☐ Housing Case Management: (*check all that apply)*

- ☐ Benefits Assistance
- ☐ Budgeting
- ☐ Mediation Services
- ☐ Obtaining Housing
- ☐ Other: _____

☐ Financial Assistance: *(check all that apply)*

- ☐ Rent $_____ x _____ months
- ☐ Mortgage $_____ x _____ months
- ☐ Utility $_____ x _____ months
- ☐ Application Fee $_____
- ☐ Moving Expense $_____

10. Describe the unexpected financial hardship experiences arising from the client's HIV health condition or change in economic circumstances.

If rent, utility, and/or mortgage assistance is requested:

11. Describe how the client will maintain their housing following receipt of financial assistance, if approved.

12. Has the client attempted to access assistance to address their need? Select One

If YES: **12a. Please explain, e.g. indicate the agency(ies) contacted and if the client did this independently or with the assistance of a professional.**

If YES: **12b. Briefly explain the outcome of the effort to obtain assistance.**

Additional Information

13 Preferred language: _____

14. Is an interpreter needed? Select Yes or No

15. Is transportation needed for housing services? Select Yes or No

16. Does the client have any mental health/substance abuse concerns that may impact housing services? Select Yes or No

If YES: ☐ Mental health concern/diagnosis **16a. Please explain:** _____

☐ Substance abuse concern **16b. Please explain:** _____

17. Provide any additional information regarding the client.

OFFICE USE ONLY

Referral Received: _____/_____/_____ **Was Information Missing?** ☐ Yes ☐ No

Describe Missing Information/Interaction w/Referral Source: _____

Request for Missing Information: _____/_____/_____ **Missing Information Received:** _____/_____/_____

E-mail Confirmation of Receipt of Referral to Referral Source: _____/_____/_____

Determination of Housing Service Provider:

☐ RWA Housing ☐ HOPWA-STRMU: ☐ Equitas Health ☐ LFCAA (lwilson@faircaa.org)

Referral Forwarded: _____/_____/_____ or ☐ NA

Referral Received: _____/_____/_____ or ☐ NA

Assigned Housing Case Manager: _____

Housing Case Manager Contact Information E-mailed to Referral Source: _____/_____/_____

HOPWA STRMU Clients Only:

Had contact with a primary health care provider consistent with the schedule specified in client's ISP: ☐ Yes ☐ No

Accessed and maintained medical insurance/assistance: ☐ Yes ☐ No