



Community Lodgings, Inc.

Office Use Only:  
Info Rec'd by: \_\_\_\_\_  
Applicant/Agency contact:  
\_/\_/\_  
Application granted: Y/N  
Intake Date: \_/\_/\_ Time: \_\_\_\_  
Unit Size: \_\_ bedroom

**REFERRAL FORM  
FOR  
APPLICATION TO TRANSITIONAL PROGRAM  
(To be completed by the referring social/case worker)**

**Agency/Shelter information**

Agency/Shelter Name: \_\_\_\_\_  
Contact Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_

**Client Information**

List all members of the family that will reside in the household.

	Full Name	SS#	Sex	DOB	Employer Information
Client					
Spouse					
Other Adult					

**Children's Information.**

Full Name	SS#	Sex	DOB	School & Grade

**Reason for homelessness (Check all that apply)**

- |                                                       |                                                    |
|-------------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Unemployment                 | <input type="checkbox"/> Substance Abuse           |
| <input type="checkbox"/> Transience                   | <input type="checkbox"/> Mental Health/Illness     |
| <input type="checkbox"/> Relocation                   | <input type="checkbox"/> Domestic Violence/Dispute |
| <input type="checkbox"/> Lack of Affordable housing   | <input type="checkbox"/> Health Problems           |
| <input type="checkbox"/> Evection/Delinquent Rent     | <input type="checkbox"/> Chronic Poverty           |
| <input type="checkbox"/> Released from Jail or Prison | <input type="checkbox"/> Other: _____              |

Client/Family currently housed at \_\_\_\_\_  
Entrance Date \_\_\_\_\_ Client/Family Contact Numbers \_\_\_\_\_

**Explain Clients circumstances below:**

Please describe any progress made by the client while receiving services from your organization.  
**(Attach a copy of current service plan/goals for each family member.)**

---

---

---

---

---

---

Note any problems or areas of difficulty that have arisen during your involvement with the client and how each was resolved.

---

---

---

---

Why would this client be a good candidate for Community Lodgings Transitional Housing Program?

---

---

---

---

What is the client's work schedule and when would they be available for interview?

---

---

---

Transitional Housing Program Name:

---

*This transitional housing program must appear on the CoC's Housing Inventory Chart submitted as part of the most recent CoC Homeless Assistance application to HUD or otherwise be recognized by the CoC as part of the CoC inventory (e.g. newly established Transitional Housing program).*

Immediately prior to entering transitional housing the person(s) named above was/were residing in:

- Emergency shelter OR
- A place unfit for human habitation

**Authorized Agency Representative Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Referral Contact Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_