Medically Fragile Homeless
REFERRAL
Fax to: 805-462-8901

Date:_________________Referring Case Worker: _____________________ Agency:_____________Phone:________________

Client First Name:____________________Nickname:___________________Last Name:_____________________________

Preferred Language:___________________Date of Birth__________________Age______ Gender: M F T Other

Names of Other Adults in Household:____

Relationship:__________________ _____________________Age(s):_____ _____ Gender: M F T Other

Number of Children:_____Relationship to Children:_______________Names and Ages______________________________

____

Pets: Yes ☐ No ☐ Service Animal ☐ Type:______________________Client Phone Number:__________________

Is client currently homeless? Yes ☐ No ☐ What city does client consider home?_________________________

Medical Diagnosis and Reason for Non-Congregate Care:____

____

Please circle all that apply:

Cancer Hospice Patient Mental Health Diagnosis Alcoholism Drug Addiction Registered Sex Offender

Does client have a permanent disability? Yes ☐ No ☐ Special Equipment Needed? Yes ☐ No ☐ Type:________________

Does the client need in home services, hospice, or other medical care in home? Yes ☐ No ☐

(MFH does not provide medical care; the referring agency must ensure access and follow through of needed care)

Number of days of housing requested to ensure recovery:____________Case Planning Goals: What are the goals of the current case plan (income, physical, behavioral health etc.)____

____

Client has been made fully aware that this is temporary housing and how long of stay is requested? Yes ☐ No ☐

Explain the plan for housing upon the exit from the MFH program:____

____

When the completed and signed application and referral are received, TFS will complete at least one in person initial assessment.

_______________________________________ _______________________________________

Client Consent (Signature) Date Referring Case Worker (Signature) Date

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