

Critical Time Intervention – Referral Form

This form is only to be completed for those who are not eligible for other support services and need ongoing support services post-housing. The client must consent to these services prior to the application being submitted.

Client Name (First and Last) _____ Client HMIS ID#: _____

VISPDAT Type: _____ VI-SPDAT Score: _____

Client Phone Number: _____ Client Email (if applicable) _____

Number of Adults in the Household: _____ Number of Children in the Household: _____

Move In Date: _____ Veteran: Yes or No

Apartment Complex Name: _____

Address: _____

Landlord/Property Manager Name and Contact Information: _____

Housing Navigator Name: _____ Agency: _____

Phone Number: _____ Email: _____

Please fill out the following information to help connect individuals/families to the most appropriate supportive services:

Estimated Length of Follow Up Needed (*Check one*): 1-3mo. 4-6mo. 7-9mo 10-12mo 12+mo.

Areas of Support (*check all that apply*):

- Daily Living Skills Budgeting Mental Health Support Substance Abuse Support
 Health Employment Education Childcare/School Positive Recreational Activities

Other (*please explain*): _____

By checking this box, I acknowledge that this information will be used to initiate a potential referral and only pertinent information will be shared to connect me to the resources needed.

By checking this box I understand that my participation and engagement of services is at my will. I also understand that these support services are for my benefit and to help make my new place of residence my new home.

Date: _____ Participant Signature: _____

Date: _____ Housing Navigator Signature: _____