Matthew 25 Referral Form

Date:

Applicant

Name:	Last Name	First Name	Middle Initial		
Last 4 of SS#:		D.O.B.	Month	Day	Year
Gender:		Ethnicity:		Race:	
Phone #:	( )	E-Mail Address:			
Emergency Contact:		Emergency Contact Phone #:	( )		
Last Night Stay:		Verified Homeless	Yes ☐	No ☐	In HMIS? Yes ☐ No ☐
Amount of Monthly Income:		Source(s) of Income:			

Referral

Reason for referral:

Agency:		Contact Name:		Phone:							
Health Insurance?	Yes ☐	No ☐	Disabled / Unable to Work?	Yes ☐	No ☐						
Needs ID?	Yes ☐	No ☐	SS Card?	Yes ☐	No ☐	TN State ID?	Yes ☐	No ☐	Birth Cert.?	Yes ☐	No ☐

Relevant History

1. Physical Health / Diagnosis(es)	Yes ☐	No ☐	If yes, any relevant information or accommodations (ambulation issues, oxygen use, service dog, etc):
1.a. Medications	Yes ☐	No ☐	If yes, any relevant information:
2. Alcohol / Drug Abuse	Yes ☐	No ☐	If yes, any relevant information including last use:
2.a. Past A&D Treatment	Yes ☐	No ☐	If yes, any relevant information:
3. Mental Health / Diagnosis(es)	Yes ☐	No ☐	If yes, any relevant information (include diagnoses and acute concerns/issues):
3.a. MH Medications	Yes ☐	No ☐	If yes, any relevant information:
4. Employment	Yes ☐	No ☐	If yes, any relevant information:
5. Legal History	Yes ☐	No ☐	If yes, any relevant information:
5.a. Sex Registry	Yes ☐	No ☐	If yes, any relevant information:

Please attach a copy of Matthew 25 Application with referral form

APPLICATION

Referral Agency _____

Name _____

Phone _____

1. FIRST NAME _____ MIDDLE _____ LAST _____ 2. AGE _____

3. SSN#_____ 4. PHONE/CELL _____ 5. BIRTH DATE __/__/____

What best describes you? You may choose more than one:

____ Asian ____ Black African-American ____ White ____ Other (Please list) _____

6. Are you of Hispanic or Latino origin? ☐ Yes ☐ No. 7. Are you a veteran? ☐ Yes ☐ No

8. Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

9. Are you paying child support? ☐ Yes ☐ No 10. Are you paying alimony? ☐ Yes ☐ No

Education & Military Service – Did you receive? ☐ High School Diploma ☐GED ☐College Degree ☐ Certificate

Military Service? ☐ Yes ☐ No Years of Service? _____ Branch of service? _____

Type of discharge (Please circle) H DH OH MD Retired

MEDICAL & DISABILITY INFORMATION

1. Check all that apply to you:

☐ Alcohol abuse ☐ Development disability ☐ Mental health ☐ HIV/AIDS related condition

☐ Alcohol & drug abuse ☐ Drug abuse ☐ Physical ☐ Chronic Health Condition

2. Are you receiving medical/psychiatric services for your disability? Y N Are you taking any prescription meds? Y N

3. Do you have a disability of long duration? ☐ Yes ☐ No ***Date of disability determination**_____

4. Do you have health Insurance? ☐ Yes ☐ No. **Start Date** __/__/____

**** CHECK THE INSURANCE THAT APPLIES TO YOU ****

☐ Medicaid ☐ Medicare ☐ Private pay health insurance ☐VA Medical Services ☐Employer provided health insurance

☐ Other_____

5. Are you under a doctor's care? ☐ Yes ☐ No When was your last TB test? _____

6. Have you ever been in an alcohol or drug treatment program? ☐ Yes ☐No How many times? _____

When? _____ Where? _____

Drug of choice? _____ Last time you drank or used? _____

7. Will you have trouble living together with 40 other men? ☐ Yes ☐ No

8. Do you have any of the following mental health problems? ☐ Depression ☐ Panic Attacks ☐ Personality Disorders

☐ Anxiety ☐ Schizophrenia ☐ Other

NON CASH MONTHLY BENEFITS

$____.____Supplemental Nutrition Assistance Program (**SNAP**) (known as food stamps)

DOMESTIC VIOLENCE

Are you a domestic violence victim/survivor? ☐ Yes ☐ No Check the one below that applies to you, if any:

☐ Within the past three months ☐ Three to six months ago ☐Six months to a year ago ☐ One year ago or more

Are you still fleeing the domestic situation? Y N

RESIDENTIAL & CONTACT DATA

Last Permanent Address: (where you resided 90 days or more)

ADDRESS _____ CITY _____

STATE _____* ZIP CODE_____ *When* did you leave this address? (month & year) _____/_____

*EMERGENCY CONTACT _____ *Relationship* _____ PHONE ___-___-____

ADDRESS_____CITY_____STATE_____ ZIPCODE_____

HOMELESS SITUATION

1. Where did you sleep last night? _____
2. Where do you plan to stay tonight? _____
3. If you were with family or friends, how long have you been there? _____
   *How much longer can you stay? _____

****

Eviction Status: If you are *currently housed, but being* evicted, answer the following questions:

Has a 3-day notice been issued? Y N Date of eviction: ____/____/____

Have you been to court? Y N Upcoming Court Date: ____/____/____

Do you have past evictions? Y N If yes, how many? _____ Do you owe any money? Y N

If yes, indicate the amount owed. _____ Who is the money owed to? _____

Hotel or Motel: If you're staying in a motel, who is paying for it? _____

Emergency Shelter Info:

If you have stayed at a shelter, do you have an exit date? Y N Please indicate: ____/____/____

4. Approximate start date of homelessness: ____/____/____
5. Regardless of where you stayed last night, *how many times* have you been on the streets or in emergency shelters/safe havens in the last 3 years? _____
6. How many *months* were you were homeless on the street or in emergency shelters/safe haven in the last 3 years? _____

*Check where you were the *night* before entering Matthew 25, Inc.*

- ☐ Place not meant for habitation (e.g., a vehicle, an abandoned building, or anywhere outside)
- ☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher
- ☐ Safe Haven
- ☐ Jail, prison or juvenile detention facility
- ☐ Substance abuse treatment or detox center
- ☐ Hotel or motel paid for without emergency shelter voucher
- ☐ Owned by client, no ongoing housing subsidy
- ☐ Other _____
- ☐ Psychiatric hospital or other psychiatric facility
- ☐ Hospital or other residential non psychiatric medical facility
- ☐ Staying or living in a friend's room, apartment or house
- ☐ Staying or living in a family members room, apt. or house
- ☐ Rental by client with no ongoing housing subsidy

Length of stay in previous place:

- ____ One night or less
- ____ Two to six nights
- ____ One year or longer
- ____ One week or more, but less than one month
- ____ One month or more, but less than 90 days
- ____ 90 days or more, but less than one year

TOTAL MONTHLY INCOME & SOURCE

Income from any source? Y N

$ _____ Earned income (employment) $ _____ Private disability insurance

$ _____ Unemployment insurance $ _____ Workers compensation

$ _____ Supplemental security income (SSI) $ _____ Social Security (SS)

$ _____ Social security disability (SSDI) $ _____ General assistance (GA)

$ _____ VA service connected disability $ _____ Pension or retirement from a former job

$ _____ VA NON- service connected $ _____ Other _____

EMPLOYMENT INFORMATION

1. Are you currently employed? ☐Yes ☐No If yes, how many hours do your work each week? _____
2. **Start Date** ___/____/____ ***Insurance** ☐ Yes ☐ No
3. Employer _____ Address _____

   City _____ Phone # _____ Supervisor's Name _____

   Full-time _____ Part-time _____ Pay rate/hour _____ Monthly Current Gross Income _____