Reset Form Print Form

ALAMEDA COUNTY Behavioral Health Care Services
ALCOHOL, DRUG & MENTAL HEALTH SERVICES

HSO HOUSING SERVICES OFFICE
1404 Franklin Street, Suite 200
Oakland, California 94612
(510) 891-8928 / FAX 1 (877) 341-5867

BHCS-Housing Services Office Emergency/Interim Housing Referral

Instructions: Fax this Referral Sheet and Client information (including Release of Information form; homeless verification, and other supporting clinical information and documents) to **HSO (Fax #: 877-341-5867)**.

Date Referral Made: _____

Please check the shelter(s) where you would like to submit this referral and rank the preferences:

☐ **EOCP Crossroads (Oakland)** ___ ☐ **BOSS SCHP (Hayward)** ___

Name of Individual Referred: _____ Applicant Social Security #: _____

Applicant Date of Birth: _____ Sex: ☐ Male ☐ Female

Applicant Telephone Number, if applicable: _____

Referring Service Provider/Case Manager: _____

Referring Service Team or Program: _____

Referring Service Provider Phone Number: _____

Referring Service Provider E-mail Address: _____

Follow-up Service Provider Staff Contact (if different from above)

Name of Service Provider/Case Manager: _____

Name of Service Team or Program: _____

Service Provider Phone Number: _____

Service Provider E-mail Address: _____

Briefly describe the applicant's current housing situation:

What is the applicant's current income and source(s) of income? _____

How will the applicant get to the emergency/interim housing site (transportation)? _____

Is the applicant willing and able to live in a shared living/communal environment? ◯ Yes ◯ No

Is the applicant currently at risk of hurting themselves or others? ◯ Yes ◯ No

Does the applicant have a history of any behaviors that might be a concern in a community living environment? ◯ Yes ◯ No

If yes, please describe:

Applicant Name: _____

Date: _____

Does the applicant have a substance abuse history?
If yes, specify: _____ Last use: _____

Is the applicant a registered sex offender? ◯ Yes ◯ No

Does the applicant have any health conditions or physical limitations that require care and supervision or that might impact the health of other residents in the program? ◯ Yes ◯ No

If yes, please describe:

Tuberculosis clearance attached (within past 12 months): ◯ Yes ◯ No

Release of information obtained & attached for services coordination: ◯ Yes ◯ No
(Must be included in order to forward medical records to a third party)

3rd Party Verification of Homelessness on letterhead from your agency: ◯ Yes ◯ No

Next Mental Health Appointment (Counselor, Psychiatrist, Service Coordinator, or other)

Date and Time: _____

Provider Name: _____

Provider Address: _____

Provider Phone #: _____

What are the applicant's most important expressed goals at this time?

What are the referring provider's plans for supporting this person after they move to the emergency/interim housing site?

Current Medications

Note: The emergency/interim housing sites request that people turn in their medication to the front desk in order to ensure the safety of the medications and the availability of support regarding medication reminders.

Is the individual currently taking any medications? ◯ Yes ◯ No

If yes, please list them below (or submit on separate document):

Name	Dose	Reason	Prescribed by?