



ALL Housing First Programs Assessment Request

To: Jacob Lile From: _____
Fax: (650) 458-2750 Date: _____
Phone: (650) 685-5880 ext. 138 Pages: _____, including cover sheet

Case Manager Name: _____ Phone#: _____

Referring Shelter or Program: _____

HMIS Household ID# _____ Total number in household _____

APPLICANT INFORMATION

Shelter entrance date: _____

Adult 1: _____

Adult 2: _____

Phone: _____ Best time to meet: _____

Total Monthly Income: _____ Source of Income: _____

Total amount saved: _____

Does household have ability to increase income within 90 days? _____

Has the client completed AOD treatment in San Mateo County within the last 24 months? _____

Has the client received rental subsidies from any of the following programs?

Section 8 Moving to Work HPRP AOD Housing Readiness Program (HRP)

Participation in any of these programs does NOT disqualify anyone from being eligible for an assessment

Additional Information: _____

Completed by: _____ Date: _____

SUPPORTING DOCUMENTS TO INCLUDE WITH REFERRAL

INCOME VERIFICATION COPY OF ID HOMELESS CERTIFICATION PROOF OF VETERAN STATUS

HOUSING FIRST STAFF USE ONLY

Notes: