



Shelter Referral Form



Date of Referral: _____

Requested Date of Transfer: _____

Referring Organization: _____

Contact Person's Name: _____

Referred Client Name: _____

Date of Birth: _____

STEP ONE: Complete basic eligibility screening

The client is NOT ELIGIBLE if any of these answers are "NO".

- Does the referred client have **some form of photo** ID in their possession? YES NO
- Does the referred client identify as a male age 45+ OR a female age 18+? YES NO
- Does the client have **NO** registered sex offender status? YES NO
(NOT sex offender) (Sex offender)
- Is the client able to self-care, meaning they are able to:
 - Eat on their own without any assistance? YES NO
 - Ambulate around the shelter without any assistance? YES NO
 - Bathe daily and use the restroom when needed without any assistance? YES NO
 - Get into and out of a bed/top bunk without any assistance? YES NO
- The client has no more than two bags of belongings weighing 25 lbs. each? YES NO

STEP TWO: Identify special needs

A "YES" answer indicates you are requesting referral to the program listed in italics.

- Bottom Bunk:*** Is the client unable to climb a ladder and sleep in a top bunk? YES NO
- Respite:*** Does the client have an acute medical condition or a mismanaged chronic medical condition that would benefit from additional monitoring and support by licensed medical staff? YES NO
- Sisterhood:*** Does the client identify as a female and have a mental health disorder as well as a history of trauma that would benefit from a structured program with daily life skills classes? YES NO

Austin Street cannot accept verbal referrals. Referral forms must be received 24 hours in advance of the referred arrival date. Referrals who do not arrive for intake before 1PM will lose their bed reservation and another client will be assigned.

How to refer your client or patient

- E-mail the completed Screening Form to ASCReferrals@austinstreet.org.
- Austin Street staff will reply to staff member of referring agency whether client is approved or denied for entry.
- If we approve the referral, we will notify the referring organization with the approved intake appointment date/time. **Referral Intakes occur Monday – Friday 11am – 1pm. We encourage referrals be sent in over weekends for Monday intake. Intake cannot be guaranteed if the client arrives outside of the appointment window.**

Client Signature: _____

Date: _____

I, the contact person, attest that the above answers are true to the best of my knowledge. I understand that if ASC staff finds the above statements to be untrue it could hinder our referral partnership.

Contact Person Signature: _____

Date: _____