



**Eagle Star Housing Referral Form**

**Supportive Housing for Veterans**

Helping homeless Veterans in upstate New York since 2012

Resident Name: \_\_\_\_\_ Referral Date: \_\_\_\_\_  
Resident Phone #: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Email: \_\_\_\_\_ Gender Identity: \_\_\_\_\_

Current Address: \_\_\_\_\_  
Current Living Situation:      Shelter      Homeless      At Risk of homelessness      Unstably Housed

Social Security #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_  
Dates of Military Service: \_\_\_\_\_ Military Discharge Status: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Email: \_\_\_\_\_  
Does the prospective resident have any therapy animals?      Yes      No  
    ~ If yes, does the prospective resident have any documentation for the animal?      Yes      No

Referral Agency: \_\_\_\_\_ Referred by: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Eligibility Determination: *Service eligibility includes any person who has served in the Military, is considered homeless or unstably housed and requires assistance with activities of daily living.*

Which category of organization is making the referral?

Shelter	Hospital	SPOA	Continuum of Care
Medical Respite	DSS	Skilled Nursing Facility	Veterans Organization

Are VA services received?      Yes      No – *If no, are they eligible?*      Yes      No

With which home management activities does the person need assistance?  
\_\_\_\_\_  
\_\_\_\_\_

Please describe current situation and what led to the need for assistance?  
\_\_\_\_\_  
\_\_\_\_\_



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Medical Doctor Name:

\_\_\_\_\_

Agency: \_\_\_\_\_

Phone #: \_\_\_\_\_

Other Clinical/Medical Provider Name:

\_\_\_\_\_

Agency: \_\_\_\_\_

Phone #: \_\_\_\_\_

Other Clinical/Medical Provider Name:

\_\_\_\_\_

Agency: \_\_\_\_\_

Phone #: \_\_\_\_\_

Other Clinical/Medical Provider Name:

\_\_\_\_\_

Agency: \_\_\_\_\_

Phone #: \_\_\_\_\_

Risks (please check all that apply and note date of occurrence if appropriate - state NA if not applicable):

- Engaged in arson (date: \_\_\_\_\_)
- Destruction of property (date: \_\_\_\_\_)
- Sexual offenses toward others (date: \_\_\_\_\_)
- Violent criminal offenses toward others or property (date: \_\_\_\_\_)
- Physical harm to others (date: \_\_\_\_\_)
- Suicide attempt/self-injury (date: \_\_\_\_\_)
- Victim of physical or sexual abuse (date: \_\_\_\_\_)

Other previous or current legal involvement:

\_\_\_\_\_

\_\_\_\_\_

Medical Issues (please check all that apply):

History of falls	Incontinence	Hearing loss	Vision loss
Impaired ability to walk?	Yes	No	
~ If yes, the resident uses a (please check all that apply):			
	Walker	Wheelchair	Transfer Chair

Medical Concerns/Comments/Other Information:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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Mental Health Diagnoses (be specific to include Axis 2 Diagnoses):

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Substance Abuse Diagnoses and frequency of use (be specific):

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*Please complete the following - responses should be 'No Assistance Required' or 'Assistance Needed':*

Manage their personal care needs (grooming, hygiene, laundry, cleaning, etc):

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Use their own transportation, public transportation, and other community resources:

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Respond appropriately to emergency situations (i.e medical, fire):

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Follow through with appointments and other responsibilities:

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Plan, shop and prepare meals:

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Manage their own money:

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*Please describe the resident's previous:*

Independent living experience:

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Drug/alcohol treatment history:

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Interpersonal skills/supports (including family):

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Hospitalizations (causes and dates):

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Does the resident comply with their medication regime?

Yes No

~Is resident self-medicating?	Yes	No ~ If no, are supports in place to assist	Yes	No
~Filling their own prescriptions?	Yes	No ~ If no, are supports in place to assist	Yes	No

Funding (please check all sources of income recipient currently receives):

SSI - \$ _____ per month	Alimony - \$ _____ per month
SSD - \$ _____ per month	Employment - \$ _____ per month
SSP - \$ _____ per month	Pension - \$ _____ per month
DHS - \$ _____ per month	Trust Fund - \$ _____ per month
SNAP Benefits - \$ _____ per month	Other - \$ _____ per month

Assets (please list all assets):

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Debts (please list all debts, including past utilities, child support, credit card debt, etc):

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Does the resident have:

~ Medicare?	Yes	No	- If yes, Medicare #: _____
~ Medicaid?	Yes	No	- If yes, Medicaid #: _____
~ Private Insurance?	Yes	No	- If yes, plan and #: _____
~ Representative Payee?	Yes	No	- If yes, agency: _____

Required Documents (please **check** all documents in resident possession):

DD-214	Bank Statements
Social Security Card	Previous Year Tax Returns or 1099
Birth Certificate	Pay Stubs
Photo Identification	Alimony/Child Support Documents
Social Security Award Letter	Proof of Assets or Mortgage



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\*\* Please provide the most recent psychosocial evaluation, psychiatric assessment, or needs assessment as indicated and any other assessments that may be helpful. This will expedite the referral process.

Signature below indicates this potential resident is medically and psychiatrically stabilized, does not need a higher level of care and is considered appropriate for the Veteran Supportive Housing Program. To the best of my knowledge, the potential resident meets the eligibility criteria listed above.

**Signature of Referral Agent:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(required)

Print name and title: \_\_\_\_\_

**Signature of Resident:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(required)

Print name: \_\_\_\_\_

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Completed referrals can be submitted to:  
Michelle Laraby, LCSW - House Administrator  
Eagle Star Housing  
[mlaraby@eaglestarhousing.com](mailto:mlaraby@eaglestarhousing.com)  
585-667-1284