|  |  |
| --- | --- |
| **Urgent –Does individual need an expedited intake?** [ ]  Y [ ]  N  | **Is the household currently enrolled in Matching Grant?** [ ]  Y [ ]  N |

**DATE**:

**Referring Agency:**

Referred by: Agency/Program:

Phone: Fax: E-mail:

Address: City: State: Zip:

Would you like an update on status of enrollment? [ ] YES [ ] NO

**PERSON BEING REFERRED:**

Name (Last, First):

Primary Phone: Secondary Phone/e-mail:

Address:

City: State: Zip Code:

Gender: [ ]  Female [ ]  Male [ ]  Other DOB: DOA:

Country of Origin: Ethnicity: Resettlement Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the client comfortable communicating in English: [ ]  Yes [ ]  No Preferred Language(s):

Immigration Status: (Helps determine eligibility for programs)

☐ Refugee ☐ LPR (Green Card) ☐ Asylee ☐ Citizen ☐ Undocumented ☐ Unknown ☐Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the client aware of this referral? [ ]  Yes [ ]  No

RHS-15 Completed? [ ]  Yes [ ]  No [ ]  Unknown **If yes, please attach copy of RHS-15.**

RHS-15 Related Follow Up (Referrals) Needed? [ ]  Yes [ ]  No [ ]  N/A

Please complete the following questions in regards to client needs to determine eligibility.

 Yes No

1.) [ ]  [ ]  Does the client have medical needs that require extensive follow-up?

 Yes No

2.) [ ]  [ ]  Does the client need an additional medical referral (SSDI, PCA, IDS, or others)?

 Yes No

3.) [ ]  [ ]  Does the client or family member have a developmental disability?

**DESCRIPTION OF CLIENT NEEDS:**

Consent for Referral: Please sign below to give referral source consent to send this completed form to Nationalities Service Center as referral to **INSPIRE**. By signing you are not enrolled in this program and a member of our staff will contact you to set-up a time to meet and talk with you more about it.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_