COMMUNITY HOPE, INC.
Referral / Application
Transitional Housing and Supportive Living (CHOICE) Programs

Applicant Name: ______________________________ Date: ________________

Address: ____

Phone: ______________________________ USTF ID#: ________________
Office use only

Contact Name: ____

Phone: __________________________ Relationship to applicant: ________________

Is the consumer currently homeless? ☐ yes ☐ no County of origin: ________________

D.O.B.: ____________ Age: ______ Social Security #: ________________

Gender: ______________ Marital Status: ________________

Income Source & Amount: ____________ Insurance # (Medicaid/Medicare): ____________

Current Living Arrangements: ________________________________

Reason Referred: ________________________________

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Psychiatric Treatment Information (include psychiatrist): ________________

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Diagnosis: ____

Medical Information: ________________________________

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Medications & Prescribing MD: ________________________

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Personal Information (family, cultural, education, vocational, legal): ____________

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Substance Use/Abuse Information: ________________________

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☐ Check here, if the consumer or family authorizes the addition of family contact information to the CH mailing list.

Eligibility Determination form to be completed by intake personnel following review of Referral/Application

________________________________ ____________

Signature of Individual Completing Form Date

________________________________ ____________

Signature of Community Hope Employee Reviewing Form Date