Family Center
OF WASHINGTON COUNTY

FAMILY SUPPORTIVE HOUSING
REFERRAL FORM

Date of Referral: _____

Head of Household Name: _____ Age/DOB: _____ Gender: F or M

Number of Household Members (and ages): _____ children _____adults

Head of Household Contact Information: _____

Mailing Address: _____

Referral Source/Agency: _____

Phone Number/Email Address: _____

Reason for Referral:

- ☐ Screening for Family Supportive Housing Program
- ☐ Other:

_____

Homelessness
Families must be currently homeless per HUD definition.

Please describe the family's current housing situation.

_____
_____
_____
_____

History of Domestic Violence? (Past or Current) Y ☐ N ☐

_____
_____

Active Department of Corrections Case: Y ☐ N ☐ (please indicate which household member, probation or parole, and underlying sentence?)

_____
_____

Active DCF- Economic Services Case: Y ☐ N ☐ (Food Stamps, Health Care, Reach Up, General Assistance?)_____
_____

Active DCF- Family Services Case: Y ☐ N ☐ (CHINS, YIT, Child who has aged out of system)

_____
_____
_____

Active DCF- Office of Child support case? Y ☐ N ☐ Either as Non-Custodial Parent (NCP) or Custodial Parent (CP) _____

_____

Active Vt. Department of Health Case: Y ☐ N ☐ (WIC, Healthy Babies, etc.)

_____

_____

History of Substance Abuse: Y ☐ N ☐ (Intensive Outpatient, Turning Point, AA/NA, BAART, other substance abuse services?)

_____

_____

Active Washington County Mental Health Case: Y ☐ N ☐ (CRT, Developmental Disabilities, or has Case Manager and services)

_____

_____

- Not Active, but has Mental Health issues or Developmental Disabilities (Past or Current, Self-Disclosed) if known please explain: Y ☐ N ☐ _____

_____

_____

_____

_____

Referral Details

Please provide any additional information that would be helpful regarding this individual/family:

_____

_____

_____

Family Supports

Please fill in those who are a support to this family

Reach Up Contact Name and Information: _____
Community Health Team Contact Name and Information: _____
Voc-Rehab Contact Name and Information: _____
Community Action Contact Name and Information: _____
Parent-Child Center Contact Name and Information: _____
Circle Contact Name and Information: _____
WCMHS Contact Name and Information: _____
Turning Point Center Contact Name and Information: _____
Probation and Parole Contact Name and Information: _____
CIS Contact Name and Information: _____
Adult Basic Education Contact Name and Information: _____
Other: _____

This form must be sent to: Kathi Partlow, Service Coordinator
383 Sherwood Drive, Montpelier, VT 05602
FSH@fcwcvt.org
Fax 802-262-6070

FCWCVT USE ONLY

Received: _____Assigned to: _____ Disposition: _____