

Bethsaida Community, Inc.
HWDT (Homeless Women Deserve Treatment)
INTAKE/REFERRAL FORM

Client's First Name: _____ Middle Initial: _____ Last Name: _____

Gender: _____ (If known) Date of Birth _____ Social security# _____

Ethnicity: _____ Race: _____

Phone numbers where client can be reached: _____

Email address where client can be reached: _____

Speaks English Speaks Spanish Speaks Chinese Other language _____

Any special needs/accommodations needed for this client? (ie deaf, visually impaired) If yes, please explain: _____

Current living situation (where is she staying? ex. car, streets, shelter) – please include city & state: _____

If client is being referred by an agency, what is the name of the agency? _____

Name of person making the referral: _____ Relation to client: Family Friend Other
 Lead case manager
 Other case manager

Phone # for referring person: _____ Email for referring person: _____

Emergency contact 1 (name, phone #, email address, relationship to client)

Emergency contact 2 (name, phone #, email address, relationship to client)

HOMELESS SITUATION:

(please check one)

- Currently homeless
- Losing housing now
- Unstable housing or
At risk of losing housing
- Don't know
- Refused

Is the client chronically homeless?
 (has a disabling condition & has been
 homeless for 1 year or homeless
 4 times in the past 3 years)
 YES NO

Has she been homeless for more than 6 months? If
 yes, please check all of the following that apply:

<input type="checkbox"/>	1) more than 3 hospitalizations or emergency room visits in a year
<input type="checkbox"/>	2) more than 3 emergency room visits in the previous three months
<input type="checkbox"/>	3) aged 60 or older
<input type="checkbox"/>	4) cirrhosis of the liver
<input type="checkbox"/>	5) end-stage renal disease
<input type="checkbox"/>	6) history of frostbite, immersion foot, or hypothermia
<input type="checkbox"/>	7) HIV+/AIDS
<input type="checkbox"/>	8) Has mental health issues, substance abuse, and chronic medical condition

Military status: Active military service No military service Veteran

Is client pregnant now? YES NO

Client is homeless alone Client has her children with her Total # of children with her: _____
 Ages of children with her: _____

What town/city is the client from (last permanent address)? _____ What state? _____

This form can be faxed to (860) 886-0620, scanned & emailed to LakishaLQ@BethsaidaCT.org or telephone referrals can be made by calling Lakisha Lee-Olson at (860) 886-0622 x 10