



Heartland Family Service – Homeless Services

Referral Screening Form

This form is designed to be completed by the provider. Questions are to be answered by the client.

Program Applying for: Rapid Re-Housing Solutions Samaritan

Client Name _____ DOB _____ SSN _____

Address _____ Phone _____

Referring Organization _____

Worker Name _____ Phone _____

*** Confirm that head of household is 19 or over & has a valid social security number**

1. Have you ever received or requested services from Heartland Family Service? If yes, which program(s) and when? What was the result?
2. How many individuals are in your household? Are you single, married, in a relationship?
3. Please describe your current living situation? Do you have a discharge date (if applicable)?
4. How long have you been homeless? How many times have you ever been homeless?

See below chart for program eligibility

Current Living Situation	Eligible Program
Emergency shelter	RRH, Solutions, Samaritan
Psychiatric hospital/facility	RRH*
Jail/Prison	RRH*
Living with family/ friends	NOT ELIBIBLE
Foster care/ group home	NOT ELIBIBLE
Transitional housing for homeless	RRH**, Solutions**, Samaritan**
Substance abuse treatment (inpatient)	RRH*
Rental housing	NOT ELIBIBLE
Place not meant for habitation	RRH, Solutions, Samaritan
Permanent supportive housing	NOT ELIBIBLE
Hospital	RRH*
Own house	NOT ELIBIBLE
Hotel/ motel	NOT ELIBIBLE
Fleeing domestic violence	RRH***

* Stay must have been for 180 days or less AND was sleeping in emergency shelter or place not meant for human habitation immediately prior to entry

** If graduating or timing out from transitional housing

***If RRH assistance is needed to leave domestic violence (see questions below)

5. Do you have any physical, mental health or substance abuse diagnosis? Is this condition of long duration? Has it affected your ability to obtain/maintain housing?

6. What immediate housing options do you have available to you? Is there someone in your support system who may be able to provide immediate housing?

7. Are you employed? What is your current income? Are you receiving any benefits? Do you have the financial resources to obtain immediate housing?

FOR RAPID RE-HOUSING ONLY: Household must be at or below 50% of AMI

Family Size	1	2	3	4	5	6	7	8	9	10
50% AMI	24,450	27,950	31,450	34,950	37,750	40,505	43,350	46,150	48,950	51,750

8. Which of the following programs have you applied for? Please indicate if you were accepted/denied or why you have not applied for the assistance.

- General Assistance Result _____
- Health and Human Services Result _____
- Public Housing Result _____
- Section 8 Result _____
- Subsidized Apartment Result _____
- Transitional Housing Result _____
- Other _____ Result _____

9. What type, amount and length of assistance that are you requesting? Please indicate resources that you have to provide any of the below needs yourself.

- Moving Assistance Amt./Length _____
- Rental Deposit Amt./Length _____
- Rental Subsidy Amt./Length _____
- Utility Deposit Amt./Length _____
- Utility Subsidy Amt./Length _____

8. What is your long-term plan to sustain housing?

Complete attached "Authorization to Release Confidential Information" and fax to 457-7791

FOR STAFF USE ONLY

Which program is client eligible for? Rapid Re-Housing Solutions Samaritan

Was client placed on waitlist? Yes No

If Yes, which program: _____

If No, please explain reasons for denial and any referrals made: _____

Notes: _____

_____ Staff Initial

_____ Supervisor Reviewed



Heartland Family Service
AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Agency/ Individual: _____

From: Heartland Family Service
6270 North 30th Street
Omaha, NE 68112

ATTN: _____

ATTN: Rapid Re-housing Program Staff

Phone: () Fax: ()

Phone: (402) 457-7770 Fax: (402) 457-7791

RE: _____ Birth Date: _____ SSN#: _____

This is to authorize the agency/ individual listed above to [] release to and/or [] receive from Heartland Family Service confidential information, including, but not limited to, professional opinions, reports of tests and examinations, treatment summaries, diagnosis and prognosis.

This authorization (Check one box) [] - is [] - is not limited to verbal exchange of information.

I authorize the following:

- [] Treatment Summary [] Intake and Discharge Summary
[] Psychological Assessment [] Progress Notes
[] Educational Information [] Social History
[] School Records [] Financial Information
[] Substance Abuse evaluation and treatment [] Legal information
[] Health/Medical Information [] Other

The reason for this disclosure is: _____

I am authorizing the release of confidential information that is to be used in conjunction with the professional services I am receiving. I understand that no services will be denied to the patient solely because I refuse to consent to the release of information. I understand that I am not required in any way to sign this authorization.

This authorization is subject to revocation at any time except to the extent that action has already been taken on it. I understand that this authorization shall remain in effect until withdrawn or canceled by me in writing or until (date) or (event), or until I am no longer receiving services from Heartland Family Service. A copy of this authorization is as good as the original.

[] I requested and received a copy of this Authorization to Release Confidential Information.

I understand that the records released may include related drug and alcohol use information that is protected by federal confidentiality regulations. Those regulations also prohibit further disclosure of such information without my specific consent.

Print Legal Name

Parent / Guardian Signature

Sign Legal Name

Date Signed

Witnessed by

Date Signed