



# HRT Referral Form

<b>Referred By:</b>		<b>Contact Information</b>	
<b>Date of Referral</b>			
<i>Would you like follow up regarding this referral? (Y/N):</i>			
<i>Reason for referral? Please list:</i>		<i>Self Referral:</i>	
<i>Please list any agencies client is working with:</i>			
Client Information			
<b>Client Name (Alias):</b>		<b>Date of Birth</b>	
<b>Contact Information</b>	<b>Phone</b>		
	<b>Email</b>		
	<b>Other</b>		
<b>County (Select One)</b>			
<b>Current Living Situation (Please select)</b>	Comments:		
<b>Household size</b>			
<b>Identified Needs (Select all that apply)</b>	Food	Medical	Housing
	Treatment (SU, MH/BH needs)	Childcare	
	Employment	Transportation	Legal
	Other: (Please list)		
<b>Demographic Status (Select all that apply)</b>	Veteran	Domestic Violence	Substance Use
	TBI/IDD	Physical Health	Youth
	Mental/Behavioral Health	Aging	
<b>Additional Comments</b>			

Once completed, please email this form to the Homelessness Response Team at [homelessresponse@wpcog.org](mailto:homelessresponse@wpcog.org) and a member of our team will be in touch.  
Thank you for reaching out.