



CareWays Shelter
 223-225 Portsea Street
 New Haven, CT 06519

NEW HAVEN HOME RECOVERY, INC.

Phone (203) 492-4873
 Fax (203) 492-4874

INITIAL REFERRAL

Date: _____

Person Making Referral: _____ Title: _____

Agency: _____ Tel. # _____

Name of Person Being Referred: _____ Tel.# _____

Current Address: _____

SSN# _____ - _____ - _____ Date of Birth: _____ Gender: _____ Ethnicity: _____

Ages and Genders of Dependents: _____

Referral Type: (use code) _____

01 – Hospital	02 – Mental Health Provider	03 – DSS (approved/denied)	04 – Dept. of Correction
05 – Substance Abuse	06 – Self	07 – Walk in	
08 – Other (explain)			

Reason for Homelessness: (use code) _____

01 – Rent over 50% of income	02 – Eviction pending	03 – Evicted	04 – Failure to pay rent
05 – Illegal landlord lock-out	06 – Domestic Violence	07 – Lead removal issues	08 – Coming out of prison
09 – Fire	10 – New Resident	11 – Family Eviction	
12 – Other (explain)			

	Yes	No		Yes	No
Disability?	<input type="checkbox"/>	<input type="checkbox"/>	Substance abuse history?	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Issues?	<input type="checkbox"/>	<input type="checkbox"/>	Lived in public housing?	<input type="checkbox"/>	<input type="checkbox"/>
Applied for Section 8 or RAP	<input type="checkbox"/>	<input type="checkbox"/>	ATR Recipient?	<input type="checkbox"/>	<input type="checkbox"/>

Where are you/they from? (Town) _____

DSM-IV DIAGNOSIS OR CONDITION (please list full diagnosis – do NOT use ICD-9 code)

Axis I Diagnosis: _____

Axis II Diagnosis: _____

MONTHLY INCOME

TANF SSI SSD Other (specify) _____
 Total \$ _____

CAREWAYS STAFF

Admitted to Shelter? Yes _____ No _____ Referred to: _____

Date of Intake: _____

Notes: _____

