Unity Care Group Homeless Program Referral
Serving Nevada and Placer County 2020

Name: _____ **Social Security # :** _____

DOB: _____ **Age:** _____ **Gender:** Male Female Other
(Circle One)

County of Origin: _____. **Ethnicity:** _____

Last Known Address:

_____
Address City, State Zipcode

_____ _____
Phone Number Email Address

Length of Time Homeless: _____ (years/ months)

Foster Youth: Yes or No
(Circle One)

If Yes, Please provide the Agency Name: _____

Referring Party

Name: _____ Agency/Job Title: _____

Phone Number: _____ Email: _____

Relationship to Youth: _____

Check all that apply,
(Please Specify)

- ☐ Mental Health Diagnosis: _____
- ☐ Physical Disability: _____
- ☐ Alcohol and/or Drug Use: _____
- ☐ Health Concerns: _____

☐ Allergies (Food, Medications, etc): _____

☐ Other: _____

Additional Notes: _____

_____

_____

Marital Status: Single Married Domestic Partner

Registered for Selective Services: Yes or No
(circle one)

Highest Grade Level: _____. **School Attending:** _____

Current Educational Goal:

☐ H.S. Diploma: ☐ Vocational Training/Certificate

☐ College Degree ☐ G.E.D

Current Employment Status:

☐ Employed Full Time ☐ Employed Part Time ☐ Not Employed

If employed where? _____

Important Documents already attained:

☐ CA ID ☐ CA Driver's License ☐ Proof of Dependency

☐ Birth Certificate ☐ Social Security Card ☐ Other: _____

Dependency

☐ Transportation: ☐ Bike ☐ Bus

☐ Own Car ☐ Rides from friends

What Services are you Interested in Receiving?

(**Please Select all that apply..)**

☐ Alcohol and/or Drug Treatment ☐ Mental Health

☐ Housing ☐ Employment

☐ Food Stamps/ CashAid ☐ Education

☐ Obtaining Important Documents ☐ Other Community Resources

Emergency Contact:

Name: _____. Phone Number: _____

Relationship: _____

Name: _____. Phone Number: _____

Relationship: _____

Referral Contacted Date: _____

Accepted Referral Date: _____

Denied Referral Date and Explanation: _____

_____