SHIP REFERRAL FORM

Date _____/_____/_____

Name / Number of Referring Agency: _____

Name: _____ DOB**:**_____ LAST 4 SS #:_____

Phone number:_____ **Last address**: _____

is applicant pregnant c yes c no #Months pregnant _____ ****Disabled:** c yes c no

History of Domestic Violence c yes c no **Sex offender** c yes c no **Victim of Sex Trafficking** c yes c no

Substance use history c yes c no
Please check all that apply:
c Alcohol
c Benzodiazepines
c Cocaine/Crack
c Other _____

Are you in outpatient treat c yes c no
Are you on MAT? c yes c no _____
c Amphetamines
c Cannabis
c Heroin / other opiates
Date of last use: _____

Current medical Problem(s): _____

Known Allergies: _____

Mental Health Diagnosis:_____

Past / current mental health crisis, hospitalizations, suicidal ideations or attempts _____

Physical Limitations / Restrictions: _____

Is participant on Supervision? c Parole c Probation

Supervising officer: _____

Do you or your child(ren) receive?

SSI:_____
Unemployment:_____
Other:_____

Total:$_____

Insurance Type:
c Medicare
c Medicaid
c Private
c None
c VA Medical

Total Monthly Family Income: $_____

Veteran: c yes c no c don't know c refused

Where did you stay last night?
c On the street
c Emergency Shelter
c Transitional Housing
c Psychiatric Facility
c Substance Abuse/Detox Facility
c Hospital (non-psychiatric)
c Jail / prison/juvenile facility
c Domestic Violence Situation
c Living w/relatives/friends
c Apartment/house you rent
c Apartment/house you own
c Staying/living with family
c Staying/living with friend
c Motel NOT paid by ES shelter voucher
c Foster care/group home
c Permanent Supportive Housing
c Place not meant for habitation (e.g., car/bus/train/subway/outside)
c Other_____

With regard to where you stayed last night, how long have you stayed/resided there?
c 1 week or less
c more than 1 week, less than 1 month
c 1-3 months
c 6 – 12 months
c 1-2 years
c 2 years or more

What form(s) of identification does participant have? ÿ Birth Certificate _ S. S. Card _ NYS / Driver License / ID

ÿ Other _____

Emergency Contacts:
Primary Contact:
Relationship:Son_____ Name:_____
Address:_____ City:_____ State: _____ Zip:_____
Phone Number: _____

Secondary Contact:
Relationship:_____ Name:_____
Address:_____ City:_____ State: _____ Zip:_____
Phone Number: _____

Please list Children:

Name:_____ Date of Birth:_____ Sex: c Male c Female

Does child attend school / daycare? c yes c no

Name:_____ Date of Birth:_____ Sex: c Male c Female

Does child attend school / daycare? c yes c no

Application Affirmation & Authorization to Verify Information

APPLICATION STATEMENT: I certify that the above information is an accurate and complete disclosure of the requested information

Ethnicity:

c Hispanic/ Latino Origin

Race:
c African American/Black
c Caucasian
c Native Hawaiian/ Pacific Islndr
c Asian
c American Indian/AK Native
c African American & White
c American Indian/AK/White
c American Indian/AK/Black
c Asian & White
c Other Multi Racial

NOTES: