PROJECTS for ASSISTANCE in TRANSITION from HOMELESSNESS
PATH
Adult Initial Referral and Intake Form

Participant: ______________________________ Phone#: _______________ DOB:___________

Address: ____

SS#:___________________ Sex: ___ Marital Status: ___

Referral Date: ______________ Referring Agency: _____________________________________

Contact Person: ___________________________________ Contact#: ______________________

Reason for Referral: ____

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Medicaid #: ___________________________

Mental Health Diagnosis:____

Substance Use Diagnosis:____

Provider Making Diagnosis ___________________________ Date of Diagnosis _____________

Primary Care Provider: ☐ Tri-State CHC ☐ Other __________________________________

Consumer has the following urgent needs:

____ Medication Assistance ____ Mental Health Linkages ____ Homeless/At Risk

____ Emergency Shelter ____ Missed MH Appts _____ Food ____ Application for MA

____ Application for Other Entitlements ____ Dual Diagnosis Tx ____ Somatic Care (describe below)

____ Being Discharged from hospital _____ Other: ______________________________________

Additional Comments: (Please provide as much information as possible)

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