SSVF Referral Form

MERIDIAN BEHAVIORAL HEALTHCARE, INC'S

Supportive Service for Veteran Families Program (SSVF)

For more information please contact:

SSVF OFFICE: (352) 244-9827, (352) 374-5600, ext. 8360, or 1800-330-5615 ext. 8360

Email: ssvf@mbhci.org

Fax Referral to: 352-244-0463

Date: _____ Primary Reason for Referral_____

Veteran's Name: _____ Discharge Status:_____ ___**OIF/OAF Veteran** (Operation Iraqi Freedom/Operation Enduring Freedom)

S.S#_____ D.O.B_____ Gender: M F Other_____

Race: _____ Ethnicity: Hispanic /Latino or Not Hispanic or Latino

Address: _____ City_____ State: Florida

County: _____ Phone #_____

How long have you lived at this address: _____yrs _____mos.

#Adults in household_____ # of Dependent Children: _____ Ages:_____

Total number of people in household: _____ Total Monthly Household Income $_____

Is the Veteran Head of Household? **Yes or No** If no, who is the head of household:_____
Relationship to Veteran: _____

1. Is individual/family currently homeless? **Yes or No** If yes, where is individual/family currently living? _____ How long?_____
2. Is the individual family currently at imminent risk of being homeless or losing housing within 21 days ? **Yes or No** Explain_____

For Applicant: By signing below, I _____ request for SSVF program staff to conduct a SSVF program eligibility screening on behalf of my household. I also give permission for SSVF program staff to contact me to obtain additional information regarding my household if needed. In addition, I authorize SSVF program staff to contact/share information with the referring agency listed below if needed, as well as update/discuss the status and/or outcome of this referral and other related information useful to assist my family with housing stability and other supportive services. I also give permission for electronic and/or fax submission of this referral. I am aware this authorization will be valid for 12 months from date signed unless otherwise noted. I also understand I have the right to revoke this authorization by submitting request in writing to SSVF program staff at anytime.

Applicant's Signature: _____ **Date:** _____

For Referring Agency Information

Referring Agency:_____ Referring Person:_____

Phone Number:_____ Email:_____ Fax:_____

Signature: _____ Date:_____

Please Check one of the following: _____Organization request feedback Organization **does not** request feedback_____

SSVF Office Use Below

SSVF Staff:_____ Date Received:_____

Date Processed:_____ Status:_____

Date Notified Applicant of Status:_____ Date Notified Referring Agency of Status:_____