



CLIENT REFERRAL FORM

Hotel-Based Emergency & Transitional Housing
usahope.org · intake@usahope.org

REFERRAL ID: _____ DATE: _____

• Required field

SECTION 1 — PROGRAM SELECTION

Select all that apply

Domestic Violence SafeStay	Veterans Bridge Housing	Families with Children	Transitional Age Youth (15–26)
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Program-specific supplement fields appear on page 2.

SECTION 2 — REFERRING AGENCY

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Organization Name •	Organization Type •
Case Manager Name •	Title / Role •
Direct Phone •	Work Email •
Backup Contact — Name & Phone	Billing Contact <i>If different from above — for monthly invoices</i>

SECTION 3 — CLIENT INFORMATION

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Legal First Name •	Legal Last Name •	Preferred Name	Preferred Pronouns
Date of Birth • <i>MM / DD / YYYY</i>	Last 4 of SSN <i>If available</i>	Gender Identity	Preferred Language •
Client Phone <i>If safe to share</i>	Safe Contact Method • <i>Agency only / Client phone / Text only / Email</i>		
Current or Last Known Location • <i>Address, shelter name, or general description</i>			
Length of Current Homeless Episode •	Where Client Slept Last Night •		

SECTION 4 — HOUSEHOLD COMPOSITION

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Total Adults •	Minor Children • <i>Under age 18</i>	Ages of Children	Pets
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Children's School(s) and Grade(s)

For school-of-origin coordination

School Transportation Needs

SECTION 5 — URGENCY, STAY & PLACEMENT

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Urgency Level •

STANDARD <i>Within 5–7 days</i>	URGENT <i>Within 24–48 hours</i>	CRITICAL <i>Same day — immediate</i>
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Requested Start Date •

MM / DD / YYYY

Estimated Length of Stay •

Emergency 0–30 days / Transitional 30–36

Preferred City or Region

Proximity Requirement

Distance or location restriction for this client

SECTION 6 — HEALTH, SAFETY & ACCOMMODATIONS

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Accessibility & Special Needs — check all that apply

- | | | |
|---|--|---|
| <input type="checkbox"/> ADA accessible unit | <input type="checkbox"/> Ground floor / no stairs | <input type="checkbox"/> Wheelchair accessible bathroom |
| <input type="checkbox"/> Medical equipment needed | <input type="checkbox"/> Dietary restrictions or allergies | <input type="checkbox"/> Mental health support |
| <input type="checkbox"/> Substance use recovery support | <input type="checkbox"/> Transportation assistance | <input type="checkbox"/> Interpreter or translation |
| <input type="checkbox"/> Infant supplies | <input type="checkbox"/> School supplies for children | <input type="checkbox"/> Job readiness support |

Immediate Safety Concerns — check all that apply

- | | | |
|---|---|---|
| <input type="checkbox"/> Active threat or danger | <input type="checkbox"/> Abuser may know current location | <input type="checkbox"/> Active restraining order |
| <input type="checkbox"/> Child safety concern | <input type="checkbox"/> Trafficking or exploitation indicators | <input type="checkbox"/> Suicidal ideation or self-harm history |
| <input type="checkbox"/> Active warrants or probation | <input type="checkbox"/> Gang involvement or threats | |

Safety Notes

Describe immediate risks, tracking concerns, or safety planning needs. Confidential.

SECTION 7 — FUNDING & AUTHORIZATION

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Funding Source •

Funding Status •

Confirmed / Pending approval / Pending — unknown timeline

Authorized Nightly Rate

Total Stay Budget

CES Assessment Completed?

HMIS Consent Obtained?

Funding Notes

Authorization reference, grant codes, or billing notes

SECTION 8 — EMERGENCY CONTACT

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Leave blank if any contact may pose a safety risk to this client. Write "None — safety concern" if applicable.

Emergency Contact — Full Name

Relationship to Client

Emergency Contact Phone

Safe to Contact Directly?

Anytime / Only if client unreachable / Agency contact only

EXHIBIT A — Domestic Violence SafeStay Hotel Program — Additional Intake Fields

DV Partner Agency Coordinating Services

Active Restraining or Protective Order?

Active / Pending / None / Expired

Perpetrator Aware of Current Location?

Perpetrator Has Access to Weapons?

Recent Escalation or Death Threats?

Is Survivor Being Tracked?

Phone, GPS, vehicle, or other method

Check all that apply

- | | |
|---|--|
| <input type="checkbox"/> Law enforcement or court involvement | <input type="checkbox"/> Active lethality concern |
| <input type="checkbox"/> Survivor in immediate danger | <input type="checkbox"/> Children in household at risk |

Safety Plan Notes

Code word, safe contacts, tracking concerns — confidential

CONFIDENTIALITY: Hotel location must not be disclosed to any unauthorized party. California Safe at Home address protections apply to all placements in this program.

EXHIBIT B — Veterans Hotel Bridge Housing Program — Additional Intake Fields

Branch of Service •

Discharge Status

DD-214 Available?

VA Healthcare Enrolled?

Service-Connected Disability?

Disability Rating

If applicable

SSVF Provider Involved?

HUD-VASH Voucher Status

Check all that apply

- | | | |
|---|---|--|
| <input type="checkbox"/> SSVF application in progress | <input type="checkbox"/> HUD-VASH application submitted | <input type="checkbox"/> VA mental health appointment needed |
| <input type="checkbox"/> Document recovery support needed | <input type="checkbox"/> VA healthcare enrollment in progress | <input type="checkbox"/> Benefits claim in progress |

EXHIBIT C — Families with Children Hotel Stabilization — Additional Intake Fields

Reason for Homelessness

Active Child Welfare Involvement?

Child Welfare Caseworker Name & Phone

Family Services Partner Involved?

Children Enrolled in School?

School of Origin

School Transportation Needed?

Childcare Needed?

Daycare or Childcare Provider Name

Provider Phone

Provider Address

Children Attending — Names & Ages

Childcare Subsidy or Voucher Active?

Transportation to Childcare Needed?

Check all that apply

- | | |
|--|---|
| <input type="checkbox"/> School liaison contact requested | <input type="checkbox"/> Children have special education needs |
| <input type="checkbox"/> Child welfare coordination required | <input type="checkbox"/> Domestic violence present in household |

EXHIBIT D — Transitional Age Youth Hotel Independence Program — Additional Intake Fields

Age •	Youth Legal Status •	Child Welfare or Probation Involvement	Primary Reason for Homelessness
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Education Status	Employment Status	Youth Is Parenting?	Trusted Adult or Emergency Contact <small>Leave blank or write None if unsafe</small>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Check all that apply

- | | | |
|---|--|--|
| <input type="checkbox"/> Trafficking or exploitation concern | <input type="checkbox"/> Foster youth aging out of care | <input type="checkbox"/> LGBTQ+ affirming room requested |
| <input type="checkbox"/> Self-harm or suicidal ideation history | <input type="checkbox"/> Minor: guardian consent on file | <input type="checkbox"/> Minor: emancipation order on file |

For minors ages 15–17: parental consent or emancipation order required before placement. LGBTQ+ affirming placements: chosen names and pronouns honored without legal documentation.

PRIMARY CARE PHYSICIAN — All Programs (Optional)

Used only to support medication continuity or urgent medical coordination. Do not contact the physician for DV clients without written client consent.

Primary Care Physician Name	Medical Practice or Clinic
<input type="text"/>	<input type="text"/>
Physician Phone	Active Medications or Urgent Medical Needs <small>Brief description only — not a full medical history</small>
<input type="text"/>	<input type="text"/>

CERTIFICATION & CONSENT

By signing below, the authorized referring staff member certifies that: (1) they are an authorized representative of the referring organization; (2) client consent to share this information with USA Hope Foundation has been obtained, or sharing is otherwise permitted by applicable law; (3) all information provided is accurate and complete to the best of their knowledge; (4) funding for the requested placement is confirmed or actively being pursued; (5) the client has been informed that USA Hope Foundation hotel placements do not create a landlord-tenant relationship; (6) any emergency contact provided has been verified as safe to contact; (7) physician information may be used only for medication continuity and urgent medical coordination; (8) the referring organization agrees to collaborate on warm handoff, case coordination, and exit planning per the applicable program MOU. USA Hope Foundation does not guarantee placement.

I certify the above and confirm I am authorized to make this referral.

Referring Staff Signature	Printed Name	Date
_____	_____	_____

FOR USA HOPE STAFF USE ONLY

Intake Staff Name	Date Received	Urgency Confirmed	Assigned Referral ID
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Room Assigned	Check-In Date	Placement Status	HMIS Entry Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Staff Notes and Placement Decision