



AOG HPP CLIENT REFERRAL APPLICATION

New Referral
 2nd Referral Date of First Referral: _____ 3rd Referral Date of First Referral: _____

AOG HPP Medium-Term Rental Assistance AOG HPP Short-Term Rental Assistance Credit Repair/Financial Assist.
 Move-In Cost Assist. Security Deposit Assist. Utility Deposit Utility Payment

REFERENT INFORMATION				Today's Date:	Client ID
Name of Referent		Referent Company		Office Phone	Ext.
Address		Suite	City	State	Zip
Type of Service Requested				Best time to call if necessary : <input type="checkbox"/> AM <input type="checkbox"/> PM	

CLIENT INFORMATION							
First Name		Middle Name	Last Name		Suffix	Date of Birth	Age
Social Security No.	SSN Data Quality	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Blood Type	RH Factor	Marital Status	
Current Street Address			Apartment No.	City	State	Zip	
Mailing Street Address			Apartment No.	City	State	Zip	
U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	Alias		Nick Name(s) Used		Child Name, DOB, and Age (if necessary)		

Please check what best describes the current living situation of the Prospect Client:

- | | | |
|---|--|---|
| <input type="checkbox"/> Emergency Shelter | <input type="checkbox"/> Transitional Housing (for homeless) | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Psychiatric Facility | <input type="checkbox"/> Substance Abuse Treatment Facility | <input type="checkbox"/> Hotel or Motel |
| <input type="checkbox"/> Jail | <input type="checkbox"/> Prison | <input type="checkbox"/> With Family or Friend |
| <input type="checkbox"/> Foster Care Home | <input type="checkbox"/> Own room, apartment or house | <input type="checkbox"/> Outside/Non-Housing (street, park, etc.) |
| <input type="checkbox"/> Car or Other Vehicle | <input type="checkbox"/> Abandoned Building | <input type="checkbox"/> Other: <i>(Please Describe Below)</i> |
| <input type="checkbox"/> Transportation Site | <input type="checkbox"/> Permanent Housing (for formerly homeless) | _____ |

Race/Ethnicity:

- | | | |
|--|--|--|
| <input type="checkbox"/> White | <input type="checkbox"/> Black or African-American | <input type="checkbox"/> Filipino |
| <input type="checkbox"/> Korean | <input type="checkbox"/> Japanese | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Asian or Pacific Islander | <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> Guamanian or Chamorro |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Samoan | |

Is the Client Spanish/Hispanic/Latino? Select "No" if not Spanish/Hispanic/Latino.

- No, not Spanish/Hispanic/Latino Yes, Mexican, Mexican American, Chicano
 Yes, Puerto Rican Yes, Cuban

Yes, other Spanish/Hispanic/Latino: _____
 American Indian or Alaskan Native

If American Indian or Alaskan Native, specify the name of tribe and degree of Indian blood (*if known*) _____

If you are American Indian, Native American, or Alaska Native, please write the name of your Tribal or Community Affiliations. _____

Other, please specify: _____

Specific nationality descent (i.e. Irish, French, German, etc.) _____



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Cause of homelessness (check all that apply): Emancipated from Foster Care Termination from previous Program
 Domestic Violence Mental Illness Low Income Loss of job Rent increase Eviction Disability
 Divorce/Separation Substance Abuse Other: _____

Birthplace (City/State)	Height	Weight	Eye Color	Natural Hair Color
Natural Hair Texture <input type="checkbox"/> Fine <input type="checkbox"/> Straight <input type="checkbox"/> Medium <input type="checkbox"/> Wavy <input type="checkbox"/> Curly <input type="checkbox"/> Course		Body Type <input type="checkbox"/> Small Boned <input type="checkbox"/> Medium Boned <input type="checkbox"/> Large Boned		Are you left handed (LH)?or Right handed? <input type="checkbox"/> Left Handed <input type="checkbox"/> Right Handed

1. How do you feel this applicant can most benefit from the *Angels of Grace Homeless Prevention Program*?

2. Describe the applicant’s most significant problem(s).

3. Is the resident from a single parent family? Briefly describe this applicant’s family situation.

4. Other helpful comments:

Print Name	Signature	Email
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Is the Prospect Client involved in any of the following?

Mental Illness Substance Abuse HIV/AIDS and related diseases Domestic Violence
 Physical Disability/Illness Unemployment School Problems Child Welfare Services Involvement

You may return this referral via:

Personal or Mail: Angels of Grace Homeless Prevention Program
1350 Van Ness Avenue
Fresno, CA 93721

Office: (559) 268-0000
Fax: (559) 268-7728
Email: hprpinformation@gmail.com
Website: www.angelsofgrace.com