**Anka Akron Veterans Transitional Housing Program**

**3268 Ringle Road. Akron, MI 48702**

**REFERRAL FORM**

**Fax to: (****810) 213-6640** **Email to: imccormick@ankabhi.org**

**DATE OF REFERRAL:**

**Referring Agency**

Agency Name:

Name of Individual Making Referral:

Phone Number:

Email:

**Client Basic Information**

Client First Name:       Last Name:

Social Security Number:

Date of Birth:       Race/Ethnicity (optional):

Emergency Contact:       Relationship:

**Eligibility Criteria (check all that apply)**

**[ ]  Male**

**[ ]  Veteran**

**[ ]  Past or Current Psychiatric Diagnosis (please list all including Substance Use Disorders):**

**[ ]  Re-Entry from Criminal Justice System (describe):**

**INTERNAL USE:**

Date Referral Received:       Received by:

**CONTACTS**

Date:      With Whom:      Outcome:      Staff Initials:

Date:      With Whom:      Outcome:      Staff Initials:

Date:      With Whom:      Outcome:      Staff Initials:

Date:      With Whom:      Outcome:      Staff Initials:

Disposition: [ ]  Ineligible [ ]  Eligible Admitted [ ]  Eligible, Wait List [ ]  Eligible, Not Admitted

Date of Disposition: