COUNTY OF TRINITY
CLIENT REFERRAL FORM

Referral Name: ____________________________ Agency: ___________________ Date: _____________
Phone #: ________________________________Address: _______________________________________

Department Name for Referral: _________________________________ Attn: ___________________
Address: ____Phone: _______________________________

Client Name:
Last: ______________________________ First: __________________ Middle: _________________
Are you pregnant Yes_____ No ____
Parent Name (if applicable): ____
Physical Address Street: __________________________City: _______________State: ____ Zip: ______
Mailing Address Street: _________________________ City: _______________State: ____ Zip: ______

Home Phone: _______________ Work Phone: _________________ Message Phone: ________________

GENDER: Male____ Female ____ Birth date:_____________ SS#: ___________________________

Marital Status: ☐Never Married ☐Married ☐Separated ☐Divorced ☐Widowed

OTHER NAMES USED: _______________________ Maiden Name: ___________________________

Significant Other: ____

Number of Children: ________ Names and Ages: ____

____

Healthcare Coverage: ☐Medi-Cal ☐ Healthy Families ☐Medicare ☐CMSP ☐ other ________________

CalWORKs: ___ Yes ___ No ☐Assigned Department: ____

Spanish Speaking Only? ☐ Yes ☐ No Needs Interpreter? ☐ Yes ☐ No
School: ___________________________________ Grade: ____ Teacher: _______________________ ____

Needs/Concerns:

___ Drugs/Alcohol
___ Drugs/Alcohol (family member)
___ School (educational)
___ Housing
___ Medication
___ Sexual abuse
___ Family
___ Homeless
___ Neglect
___ Physical/domestic violence
___ Crisis (self or family member)
___ Behavioral
___ Social/Peer Relationship
___ Emotional/mental
___ Other: __________________
____

Referral:

___ Mental Health
__ Substance Abuse Services
___ Employment Service
___ Court/criminal justice
___ Cal Works
___ CPS
___ HHS
___ Children's Services
___ Housing and Grants
___ Other: ________________

REASON FOR REFERRAL AND OTHER SIGNIFICANT INFORMATION ____________________
____
____
____
____

Referral from a Call, Email, In person or Other

Date of call: Time: Received by (staff name) _______

Received by: Call_______ Email_________ in Person _____________Other____

Received from (X one): Self-referral ____ Private Party referral ___________ Agency referral ________

Name of Private party if not client or agency:___________________________Phone:______________________________

Is this a life-threatening emergency: YES_______ No ___ __

If sick or seeking COVID testing Yes____ Contact HHS at 530-623-1265 (check if referred out) ____________

Does a partner, or anyone in your household, hurt, hit or threaten you? Yes______No_____

In the last 6 months have you fled a relationship from, intimidation, threatened, or stalked? Yes__ No ______

Do you believe you are still in danger at this time Yes __ No ______?

Homeless? ☐ Yes ☐No how long have you been Homeless?____

What city are you in? _________________________How long have you been in that area?__________________________

Where did you sleep last night_________________________where will you sleep tonight?___________

What Area you can be found____

Are you a Veteran Yes___ No____

What is your income?_________________________Source________________Do you need SSI help? Yes______No_____

Do you have a serious health condition? Yes _____No_____Explain____

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Do you have a condition that compromises your immune system? Yes______No_____

How did you hear about Trinity County Housing and Grants Department? _______________________________

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Authorization for interagency exchange of Confidential Information to accompany this form.