Coordinated Entry Referral for Site Based Housing Programs

To be completed by housing provider describing vacant unit

Agency_____**Program Name**_____

Type of Program
☐ PSH   ☐ TH   ☐ RRH   ☐ Other _____

Unit Size (check one)

☐Studio   ☐3BR
☐1BR   ☐4BR
☐2BR   ☐Other_____

Household Composition ☐Single Adults ☐Families   ☐Youth
Family Composition (when applicable) _____Parent(s) _____Children

Parents Ages
☐18-21   ☐18- 24   ☐No preference

Location
City_____ Neighborhood_____ Cross-streets_____

Homeless Status as Required by Funder
☐First time   ☐Chronically Homeless (HUD Defined)
☐Multiple times, Not LTH
☐Long Term Homeless

Disability
☐Head of Household must have documented disability that impacts their ability to work
☐A household member must have disability
☐No requirement

Income
☐Client has legal, verifiable EARNED income and/or has Public assistance
☐Minimum Monthly $_____   Maximum Monthly $_____

Criminal or Background
Please list below any additional criteria for possible tenants. If you are excluding people please include justification for that limitation.

Sobriety
Client must be sober ☐Yes   ☐No   Please elaborate_____

Please use the back side of this form to add any additional information about the unit or programming available.

Coordinated Entry Referral for Scattered Site or Voucher Based Housing Programs

To be completed by housing provider describing vacant unit

Agency_____ **Program Name**_____

Type of Program
☐ PSH   ☐ TH   ☐ RRH   ☐ Other _____

Unit Size (check all that apply)

☐Studio   ☐3BR
☐1BR   ☐4BR
☐2BR   ☐Other_____

Household Composition ☐Single Adults   ☐Families   ☐Youth
Family Composition (when applicable) _____Parent(s) _____Children

Parents Ages
☐18- 24   ☐No preference
☐18-21

Homeless Status as Required by Funder
☐First time   ☐Chronically Homeless (HUD Defined)
☐Multiple times, Not LTH
☐Long Term Homeless (MN defined)

Disability
☐Head of Household must have documented disability that impacts their ability to work
☐A household member must have disability
☐No requirement

Income
☐Client has legal, verifiable EARNED income and/or has Public assistance
☐Minimum Monthly $_____   Maximum Monthly $_____

Criminal or Background
Please list below any additional criteria for possible tenants. If you are excluding people please include justification for each specific limitation.

Sobriety
Client must be sober ☐Yes   ☐No   Please elaborate_____

Please use the back side of this form to add any additional information about the unit or programming available.