Date Rec. Back: _____

Staff Initial: _____

Homes for Life Foundation

8939 S. Sepulveda Boulevard, Suite 460 Los Angeles, CA
90045 (310) 337-7417 phone (310) 337-7413 fax
www.homesforlife.org info@homesforlife.org

Admission Referral Form
State Licensed Board & Care Homes

Please check cities of interest:

☐ Alhambra (Almansor-Monterey) ☐ Harbor Gateway/☐ Denker ☐ Norwalk ☐ Pasadena ☐ San Gabriel (Fairview)

Today's Date _____ Referred by:_____

Client's Name:_____ SSN:_____

Address:_____ Phone No: ( ) _____

_____

_____

Date of Birth:_____Place of Birth:_____

Sex: _____ Age: _____ Ethnic Background: _____

Marital Status:_____Number of Children:_____

Educational Background:_____

_____

_____

Are You a Veteran? _____

Are you currently receiving SSI? _____

Other Sources of Income: _____

(These would include - payments received from a public agency for assistance with transportation to school, life skills and vocational rehab classes, and/or participation in a rental assistance program.Please include name of agency and monthly amount/s received. If this information does not apply - please print N/A.)

Name of Agency	Monthly $ Amount	Service(s) Covered

Comments:_____

_____

EMERGENCY INFORMATION

Spouse: _____ **Address:** _____

_____

_____

Phone Number: ( ) _____

Other Agent Entrusted: _____ **Relationship:** _____

Address: _____

_____

_____

Phone Number: ( ) _____

PSYCHIATRIC INFORMATION

Name of Psychiatrist/Psychologist:

Address: _____

_____

_____

Phone Number: ( ) _____

Name of Social Worker/Case Manager: _____

Address: _____

_____

_____

Phone Number: ( ) _____

Psychiatric Diagnosis: _____

List of Psychiatric Hospitalizations and Appropriate Dates: (Use back of page if needed.)

Hospital	Date of Admission	Date of Discharge
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Medications: _____

_____

_____

Do You/does Client Cooperate in Taking Them? _____

Do You/does Client have a Conservator? _____A Payee?_____

Address: _____

_____

_____

Phone Number: ( ) _____

Do You/does Client have a History of Substance Abuse? If so, please Describe in Detail: (Use back of page if needed.)

_____

_____

_____

History of Assaultive Behavior?_____Describe in Detail:_____

_____

_____

_____

History of Attempted Suicide(s)?_____Describe in Detail:_____

_____

_____

_____

MEDICAL INFORMATION

Do You/does Client have any Physical Disabilities? _____ **If so, please Describe in Detail:** _____

_____

_____

Any Major Illnesses:_____Current Medications Used:_____

_____

_____

Describe Your/Client's Current Health: _____

_____

_____

Any History of Tuberculosis?_____Any Family History of same?_____
Any Recent Exposure to Anyone with TB? _____

_____

PSYCHO-SOCIAL INFORMATION

Describe Your/Client's Skills, Strengths, and Deficits Related to Social Skills: _____

_____

_____

_____

Describe Your Family Network: _____

_____

_____

_____

Are You/Client Motivated to Live at Homes for Life Foundation?: _____

_____

_____

_____

_____

To my knowledge, all of the information in this application which has been provided by me is accurate.

Signed by: _____ **Date:** _____
(Parent/Guardian/Client Representative)

Client Signature: _____ **Date:** _____

MEDICAL REQUEST FORM

Submitted by:

Homes for Life Foundation

8939 S. Sepulveda Boulevard, Suite 460 Los Angeles, CA 90045 (310) 337-7417 phone
(310) 337-7413 fax
www.homesforlife.org
info@homesforlife.org

Explanation Regarding Psychiatric Information Requested:

The requesting agency, Homes for Life Foundation, is coordinating provision of long-term housing for your patient. In order that we may proceed with review of the application for residency, a psychiatric diagnosis must be obtained in writing from the patient's attending physician.

Kindly expedite such psychiatric diagnosis and have the form returned to above address.

Thank you.

Information Requested:

Patient's Name: _____

Physician's Psychiatric Diagnosis of Patient: _____

Physician's Signature: _____

Physician's License Number _____

Current Date: _____

CONSENT TO RELEASE MEDICAL INFORMATION

As part of making application to reside in one of Homes for Life Foundation's residential homes, I hereby give my consent that medical information related to myself may be released to their office.

_____ _____

(Signature of Patient/Applicant or Conservator) **(Date)**

_____ _____

(Signature of Witness/Optional) **(Date)**