LEGAL SERVICES TO END HOMELESSNESS

HAP/DBHIDS SOAR REFERRAL FORM

(Safe Havens, TCM, BHSI, JOH, Housing First)

To: **Michele Levy, Managing Attorney**
Direct Dial: 215-523-9585
mlevy@haplegal.org
Fax: 215-523-9599

Referred By:
Name: _____ **Phone**: _____

Program: _____ **Email**: _____

Re: _____ **DOB**: _____/_____/_____
(Client's Name)

Date: _____/_____/_____

Claimant's Contact Information

Cell Phone: _____ Alternative Phone: _____

Residential Address: _____

Mailing Address: _____

SSI/SSDI Claim History

Has individual applied for benefits in the past? Yes _____ No _____

If yes, date and result of most recent application/decision: _____

If individual has consulted with an attorney for purposes of obtaining SSI/SSDI benefits, identify attorney and date of most recent contact: _____

Information Relating to Mental and Physical Impairments

List Claimant's Diagnoses: _____

List Current Treatment Providers (Psychiatric and Medical): _____

_____

_____

List Current Medications and Dosages: _____

_____

Does Individual Have a History of Drug/Alcohol Abuse? Yes _____ No _____

If yes, date of last use: _____

Describe the Nature of Disabling Conditions (the limitations caused by medical and/or psychiatric problems that prevent individual from working) **and** Attach Most Recent Psychiatric Evaluation: _____

_____

_____

Vocational Factors

Date of Most Recent Employment: _____

Brief Description of Most Recent Job: _____

_____

Last Grade *Completed* in School: _____

Was Individual in Special Education Classes? Yes _____ No _____

If yes, then name and address of last school attended and year: _____

_____

Additional information, including your observations, if any:

_____

_____