SPA 6 Coordinated Entry System

Inter- Agency Referral Form

Referring Agency Information	Receiving Agency Information
Providers Name_____	Providers Name_____
Agency Name_____	Agency Name_____
Address_____	Address_____
City_____	City_____
State_____Zip_____	State_____Zip_____
Email Address_____	Email Address_____
Primary Phone_____Fax_____	Primary Phone_____Fax_____

Client Information

Full Name_____ D.O.B_____

Gender_____ Age_____ Phone Number_____

Email Address_____ HMIS#_____

SPDAT Completed_____ Next Step Tool Completed_____

Acuity Score_____ Priority Score_____

Requested Services (Please check all that apply)

- ☐ **Single Adult**
- ☐ **Transition Age Youth**
- ☐ **Family**
- ☐ **Benefits**
- ☐ **CBEST**
- ☐ **Crisis/Bridge**
- ☐ **Drug Medi-cal**
- ☐ **Employment**
- ☐ **HJC**
- ☐ **Housing Navigation**
- ☐ **HUD/VASH (Veterans)**
- ☐ **Housing for Health**
- ☐ **LEAD**
- ☐ **Legal**
- ☐ **HJC Medical**
- ☐ **Mental Health**
- ☐ **Rapid RE-Housing Shelter**
- ☐ **TAY WSP**

Supportive Services (Please Check Box)

Food ☐ **Water** ☐ **Clothing** ☐ **Shoes** ☐ **Hygiene Kit** ☐

Referral Outcome (Appointment Details)

Was the Client enrolled? Yes ☐ **No** ☐

Appointment Date/Time:_____ **Contact Person**:_____

Signature:_____ **Date**:_____

Rev.11.27.17