NEW ENGLAND CENTER
AND HOME FOR VETERANS

Provider Referral Form – Transitional Housing

Please send completed referral forms to thr@nechv.org

**required field*

Referral Contact Information

Referral Date: *

Name of Organization: *

Name of Contact/Referral Person: *

Contact/Referral Phone Number: *

Contact/Referral Email: *

Veteran Details

Name of Veteran Being Referred: *

Age: *

Date of Birth: *

Gender: *

Branch of Service: *

Discharge Status: *

Veteran Phone Number:

Is this referral for a specific program? *

If yes, which program?

Please note specific programs may have additional screening and eligibility requirements, and indicating a specific program does not guarantee admission.

Housing History

Date last permanently housed: *

Why is the Veteran currently experiencing homelessness: *

Where did the Veteran stay the most in the last 30 days? *

Where did the Veteran stay last night?

Medical Needs

Can the Veteran manage independently? (showering, medication administration, eating and bathroom hygiene) *

If not, please explain.

Does the Veteran have or need any medical breathing equipment such as a CPAP/BiPAP machine, or oxygen? *

If yes, please explain.

Does the Veteran use any medical supplies or continency products? *

If yes, please explain.

Does the Veteran have any mobility issues, or utilize any mobility devices? *

If yes, please explain.

Legal Barriers

Is the Veteran a registered sex offender? *

If yes, what level?

Is the Veteran currently on parole/probation? *

Does the Veteran have any legal issues that could be a barrier to housing?

Additional Information