PATHWAYS HOME™
Housing Coordination Program

Countywide Case Coordination Referral Form

SAN BERNARDINO COUNTY
Homeless Services

Referring Agency Information:			**Date:**
Name:		Agency:	
Phone:		Email:	

Client Information:			
Name:	HMIS UID:	Age:	DOB:
Gender:	Race and Ethnicity:	Language:	Phone:
Clients Current Location/Complete Address/Whereabouts:	Clients Current Living Situation:	Date of Last Contact with Client:	

Referral Type:

- ☐ Consultation:
- ☐ Coordination of Services
- ☐ Resources/Services:
- ☐ Other:

Health Plan Insurance:

- ☐ Medicare / Medicaid
- ☐ Medi-Cal
- ☐ Inland Empire Health Plan (IEHP)
- ☐ Kaiser
- ☐ Molina
- ☐ Senior Care Action Network (SCAN)
- ☐ Other:

Special Service Categories:

- ☐ Chronically Homeless
- ☐ Disabled
- ☐ Employment
- ☐ Families
- ☐ Foster Care
- ☐ Individuals
- ☐ Inland Regional Center (IRC)
- ☐ Literally Homeless
- ☐ Mental Health
- ☐ Parole
- ☐ Probation
- ☐ Seniors
- ☐ Substance Use
- ☐ Transitional Age Youth (TAY)
- ☐ Undocumented
- ☐ Veteran
- ☐ Victim of Crime
- ☐ Other:

Brief description of the problem:

Brief history/background:

Steps taken to resolve the situation: (i.e., agency involvement, referrals made, resources offered, etc.)

Team suggestions: