**Referral  Referral is to be emailed to the following**

**hdap@westcare.com**

***Housing and Disability Advocacy Program (HDAP)***

HDAP is comprised of two components: Disability Advocacy and Housing Services. To qualify for Housing Services, participant must be receiving Disability Advocacy services. Program participants will have to meet HUD’s definition of homelessness and meet the SOAR model criteria.

|  |  |
| --- | --- |
| Client Name:  | Client Phone Number:  |
| Client D.O.B:  | Client S.S.N:  |
| Referring Party Name:  | Referring Party Organization:  |
| Referring Party Phone:  | Referring Party Email:  |
| **Is the person assigned a Navigator?** ☐ Yes ☐ No ☐ Don’t Know | If yes, Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Is the participant document ready?** *If yes, please check all documents that the client* ***have in their possession*.** | ☐ Yes ☐ No ☐ Not Sure ☐ ID/Driver’s License ☐ SSN ☐ Birth Certificate |

**\*\**To be eligible for HDAP, the answer to the next 4 questions must be YES \*\*\****

1. Is the person unable to engage in any work activity because of a **physical** or **mental** impairment that is expected to **result in death**, or that has lasted or is expected to last for a **continuous period of at least 12 months**? ☐ **Yes** ☐ **No**

2. Does the person need help getting disability benefits?

☐ Yes, the person is NOT receiving **any** disability benefits.

☐ Yes, the person is NOT receiving the **full disability benefit** amount to which they are entitled. ☐ Yes, the person is at risk of **losing existing disability benefits** due to difficulties in completing the disability redetermination process.

☐ No, the person already has SSI, SSDI, CAPI, or all other disability benefits to which they are

entitled.

3. Has the person been verified to be chronically homeless or homeless; or are they about to be exited from an institution into homelessness? ☐ **Yes** ☐ **No**

4. Does the person’s household meet the low-income criteria under HUD definitions? ☐ **Yes** ☐ **No** ☐ **Not Sure**

***HDAP Staff Use***

|  |
| --- |
| Date of Referral Received via Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ HDAP Staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Client Status: ☐ **Approved**: Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ☐ **Deferred** due to (Check One) ☐ Prioritization ☐ Insufficient Program Capacity ☐ **Denied:** Reason for Denial \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Notified Verbally \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Notified in Writing by Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |