



Referral Form

[HOUSE NAME] — Way of Life Ministry • Send to [ORG EMAIL] or [FAX/SECURE UPLOAD], or call [INTAKE PHONE]

Please send only with the applicant's **signed consent** to share this information with Way of Life Ministry. If the information comes from a 42 CFR Part 2 program, include your program's consent and the re-disclosure notice.

Referring partner

Agency: _____

Your name & title: _____

Phone: _____

Email: _____

Date: _____

Best time to reach you: _____

Applicant (prospective resident)

Applicant name: _____

Date of birth: _____

Phone: _____

Gender: _____

Current location (program / hospital / shelter):

Expected discharge / available date: _____

Veteran? ☐ Yes ☐ No VA enrolled? ☐ Yes ☐ No SSVF / HUD-VASH involved? ☐ Yes ☐ No

Current level of care: ☐ Detox ☐ Residential ☐ PHP ☐ IOP ☐ Outpatient ☐ Inpatient psych ☐ ED
☐ Shelter ☐ Incarcerated / reentry ☐ Other: _____

Primary substance(s): _____ Date of last use: _____

On MAT? ☐ No ☐ Buprenorphine ☐ Methadone ☐ Naltrexone Prescriber / clinic:

Medically stable and not in withdrawal? ☐ Yes ☐ No Able to manage own meds and daily living?
☐ Yes ☐ No

Court / probation / parole involvement? ☐ No ☐ Yes – contact: _____

Payment source: ☐ Self / employment ☐ SSI/SSDI ☐ GA ☐ SSVF ☐ Scholarship (source: _____)
☐ Family ☐ Unknown

Ongoing outpatient / recovery supports after move-in: _____

Anything we should know to support this person well: _____

☐ Applicant's consent to share information with Way of Life Ministry is attached / on file.

We do not pay for or accept payment for referrals. Way of Life Ministry does not offer or accept money, gifts, free rent, or anything of value in exchange for referrals.

Referring staff signature

Date: _____

Way of Life Ministry use only

Received: _____

Screened by: _____

Interview date: _____

Decision: _____



Move-in date: _____

Partner notified (date): _____