

ACTION-Housing, Inc.
MyPlace Transitions Program
817 East Pittsburgh Plaza
East Pittsburgh, PA 15112
Telephone: (412) 824 - 0982

Referral Form

(To be completed and returned by the agency referring the applicant)

Name of Person you are referring: _____ Date: _____

Social Security# _____ Birth date: _____ Age: _____

Name of Agency Referring: _____

Agency Contact Name, Title and Phone #: _____

Do you currently service this individual? Yes No

How long have/did you service(d) them? _____

What service(s) do/did you provide to them? _____

Is this individual currently receiving Mental Health services? Yes No

If yes, from what agency and what location? _____

Is this individual currently receiving Drug & Alcohol services? Yes No

If yes, from what agency and what location? _____

Reason for Referral: _____

Please state any additional information we should know about the applicant:

Would you commit to the ongoing support of this applicant through the duration of this program given their acceptance? Yes No

If yes, in what way will you support them? _____

Please mail the completed form with program participant application to our office. We only accept referrals directly from the referral agency. If you have any questions please call the office.