Great Lakes
COMMUNITY ACTION
PARTNERSHIP

Youth Homelessness Demonstration Program Referral

Date: _____ Referring Agency: _____

County: _____ Staff Name: _____

Phone Number: _____ Email Address: _____

Family ☐ Single ☐ Reporting Disability Yes ☐ No ☐

Veteran? Yes ☐ No ☐ If applicable, HARP Score_____

Current Housing Status (Prioritized by level of need):

☐ Literally Homeless (Emergency Shelter, Place not meant for human habitation, hotel/motel provided by social service agency)

☐ Youth fleeing unsafe situations

☐ Imminent Risk of Homelessness (Housing loss expected within 14 days with no safe alternative housing)

Client Contact Information:

Name: _____ Date of Birth: _____

Phone Number: _____ Email :_____

Other information that may be useful for the agency to know:

_____

_____

_____

Please return document to ayhousing@glcap.org

P.O. Box 590 **1-800-775-9767** **www.glcap.org**
127 S. Front St.
Fremont, Ohio 43420
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