



### HOUSEHOLD REFERRAL FORM

Please send this form via fax to 305-919- 4053, in compliance with HIPAA

GFF NHELP Contact Person: \_\_\_\_\_

|                                     |   |  |  |                                       |
|-------------------------------------|---|--|--|---------------------------------------|
| <b>Neighborhood</b> (please √ one): | Miami Gardens: <input type="checkbox"/> | North East: <input type="checkbox"/>   | Little Haiti: <input type="checkbox"/> | Hialeah: <input type="checkbox"/>     |
|                                     | Opa Locka: <input type="checkbox"/>     | OL Extension: <input type="checkbox"/> | North West: <input type="checkbox"/>   | Miami Lakes: <input type="checkbox"/> |

Family member for contact: (print) \_\_\_\_\_

Complete address: \_\_\_\_\_

\_\_\_\_\_

Phone-cell/house: \_\_\_\_\_ E-mail: \_\_\_\_\_  
(enter C or H)

Further information (best time to call, comments, etc.): \_\_\_\_\_

\_\_\_\_\_

Referred by/title: \_\_\_\_\_

Organization: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Referral discussed with Family (Please check):

|                               |  |             |
|-------------------------------|--|-------------|
| <b>For FIU only</b>           |  |             |
| Date received: _____          | Follow-up by: _____                          | Date: _____ |
| Decision by family Y/N: _____ | Chosen for family/back-up-circle/DATE: _____ |             |
| Comments: _____               |  |             |
| _____                         |  |             |