

HOUSING SERVICES CLIENT REFERRAL FORM

PLEASE COMPLETE ALL FIELDS BEFORE SUBMITTING

Referring Agency Details					
Date of referral		Referrer Name		Contact Number	
Organisation					
Address					
Email					
Services referred	Housing <input type="checkbox"/>	Mental Health <input type="checkbox"/>	Disability <input type="checkbox"/>	Other <input type="checkbox"/>	

Client Details					
Given Name		Last/Family Name			
Date of Birth	Age	Gender	<input type="checkbox"/> M <input type="checkbox"/> F <input checked="" type="checkbox"/> X		
Address					
Home Phone	Mobile		Landline		
Email address					
Nationality		Country of Birth			
Language spoken		Interpreter Required	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Visa Subclass		Date of Arrival			
Family Composition	<input type="checkbox"/> Single <input type="checkbox"/> Single with Dependents <input type="checkbox"/> Couple <input type="checkbox"/> Couple with Dependents				
Children below 18	Ages				
Income Source of all family	DSP <input type="checkbox"/> Jobseeker <input type="checkbox"/> Parenting Payment Single <input type="checkbox"/> PPP <input type="checkbox"/> Wages <input type="checkbox"/>		CRN of all Adults:	Amount (per f.n.):	
Does the client require assistance to gain employment / additional employment Yes <input type="checkbox"/> No <input type="checkbox"/>					

Client housing needs/preferences			
Preferred Suburb(s)			
Number of bedroom(s)		Number of bathroom(s)	
Extra information	1. Does the client have rental references? Yes <input type="checkbox"/> No <input type="checkbox"/> 2. Is the client on Housing Authority Wait List? Yes <input type="checkbox"/> No <input type="checkbox"/>		

Client Consent	
I/We _____ give my /our consent for the above information to be provided to Multicultural Services Centre of WA (MSCWA) to assess my /our eligibility in relation to services provided by MSCWA.	
Client Signature:	Date:

Thank you for your referral