# HASP REFERRAL IN FORM

**(16-25 Homeless or at risk of Homelessness)**

Please email completed referral to intake@gcys.org.au

| | | | |
|---|---|---|---|
| Name of person making referral | | Date | |
| Relationship to Young Person | | Since | |
| Name of Service | | Phone | |

| | | | |
|---|---|---|---|
| Homeless | | At Risk of Homelessness | |

*Insert x as appropriate*

| **YOUNG PERSON DETAILS** | | | |
|---|---|---|---|
| First Name | | Surname | |
| Date of Birth | | Age | |
| Mobile | | Email | |
| Lives With | | Contact No | |
| Address | | Suburb | |

| **Current Status** | | **Background** | |
|---|---|---|---|
| Single | | Aboriginal | |
| Couple | | Torres Strait Islander | |
| Family | | Aboriginal and Torres Strait Islander | |
| Number of Children | | Other, please specify | |

*Insert x as appropriate*

| **REASON FOR REFERRAL** *(if you need more space please add additional page)* |
|---|
| |

| **SUPPORT AND SERVICES currently involved** | |
|---|---|
| Service /Support | Providing/Since |
| | |
| | |
| | |
| List any Risk Factors: e.g. environmental, relationships, behaviour, etc | |
| | |
| Client aware of referral/Contact (Yes/No) | |

| | | | |
|---|---|---|---|
| Referral accepted by HASP (Yes/No) | | | |
| Worker Name | | Date | |
| QHIP Assessment Completed by | | QHIP Rating | |