HEALTHY HOMES COALITION OF WEST MICHIGAN

Agency Referral Form

PLEASE EMAIL FORM TO INTAKE@HEALTHYHOMESCOALITION.ORG

REFERRING AGENCY INFO

Agency Name	
Agency Staff Name	Agency Staff Title
Agency Staff Phone #	Agency Staff Email
Primary Concern(s) ☐ Asthma ☐ Injury Hazards (carbon monoxide, fire safety, etc.) ☐ Lead Poisoning ☐ Pests ☐ Other _____	
Date of Referral	Additional Notes

PARENT / GUARDIAN INFO

Parent/Guardian Last Name	Parent/Guardian First Name
Parent/Guardian Preferred Language ☐ English ☐ Spanish ☐ Arabic ☐ Kinyarwanda ☐ Other _____	
Parent/Guardian Address (MUST include City and Zip Code)	
Parent/Guardian Phone #	Preferred Time for Calls ☐ Morning ☐ Afternoon ☐ Evening
Parent/Guardian Email	

CHILD INFO

Child's Last Name	Child's First Name
Child's Date of Birth	Does the child have an Elevated Blood Lead Level? ☐ No ☐ Yes (what is it?) _____
Does the child have an asthma diagnosis from a medical provider? ☐ No ☐ Yes (If yes, please complete the information below)	
# of asthma-related hospitalizations or ER visits in the past 6 months _____	Date of most recent hospitalization or ER visit ___ / ___ / ___

HOUSEHOLD INFO

Housing Status ☐ Rent ☐ Own ☐ Land Contract ☐ Homeless ☐ Other _____	
Housing Type ☐ Apartment ☐ Mobile Home ☐ Single Family Home ☐ Two Family Home ☐ Multi Family Home	
Year home was built ☐ Before 1978 ☐ After 1978 ☐ Unsure	Is anyone in the household pregnant? ☐ Yes ☐ No
Combined Annual Household Income	Total Number of People in Household

HEALTHY HOMES COALITION STAFF USE ONLY

Date Received	HHC Staff Name & Title
Action Steps To Complete ☐ Rapid Intake Form ☐ Enter into Salesforce ☐ Complete NIDO ☐ Assign to Healthy Housing Specialist	
Notes	