Healthy Housing Referral Form

Please complete the information below to initiate a referral for AID Atlanta's services.
Please do not leave any fields blank.

Member Name:

Member Phone Number:

Date of Referral:

Type of Referral:

Source of Income:

Monthly Income:

Criminal History: No If yes, please explain:

Evictions: No If yes, please explain:

I, (Member Name), , authorize AID Atlanta, Inc. to obtain and release the information needed to coordinate my care from and to:

Medical/Service Provider Name:
Name of Agency:
Telephone Number:

I understand that this information will be shared between AID Atlanta and the above party for the purpose of coordinating care and services on my behalf.

Member Signature: Date:

Referring Case Manager: Date:

REASON FOR REFERRAL: (please include as much detail as possible to help screen for eligibility)