CATCH Coordinated Entry Form

CATCH
Central Arkansas Team Care for the Homeless

Screened by: _____ Agency: _____ Date of Screening: _____

Participant Information			
Name:		DOB:	
Address:		Gender:	
City:	State:	Zip:	
Phone:	email:		

Prioritized Vulnerablity Criteria

Chronically Homeless: ☐ Homeless >12 months ☐ Homeless at least 4 times in the last 3 years

Veteran Status: ☐ Honorable ☐ Dishonorable ☐ N/A

Household Members: Adults: _____ Children: _____

***If client is identified to be a vulnerable population, please contact designated agency.**

For all families and chronically homeless individuals contact:
People Trust Community Housing Program (PTCHP) at 501-404-4857

Person Contacted: _____ Date and Time: _____

*For **veteran services** contact:*
CAVHS at 501-244-1900 or St. Francis House (SSVF) at 501-916-2514

Person Contacted: Date and Time:

Where did the client/family sleep last night? ☐ Shelter ☐ Friend/Family's ☐ Streets/Car
☐ Rental Unit ☐ Owns Home ☐ Other

Services Needed (Check all that apply):

Emergency Shelter ☐ Employment ☐ Substance Abuse Treatment ☐ Disability Benefits ☐
Domestic Violence ☐ Mental Health ☐ Medical ☐ Housing and/or Rental Assistance ☐
Transportation (i.e. bus pass) ☐ Birth Certificate and/or ID ☐

Referrals Out:

Agency Name:		Phone Number:	
Person Contacted:		Date and Time:	
Agency Name:		Phone Number:	
Person Contacted:		Date and Time:	
Agency Name:		Phone Number:	
Person Contacted:		Date and Time:	

I/we, _____ , authorize the staff of the _____ agency to exchange or release information to agencies within the Central AR Continum of Care for the purpose of assisting with maintaining or obtaining housing for myself/my family. Signature: _____ Date: _____

NOTICE: By entering your name in the "Signature" field above you consent to allow the referral to be sent to an agency to assist you.

If you have any questions please contact info@catcharkansas.org

Last reviewed 11.01.23