



# CATCH Coordinated Entry Form

Screened by: \_\_\_\_\_ Agency: \_\_\_\_\_ Date of Screening: \_\_\_\_\_

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

Prioritized Vulnerability Criteria	
Chronically Homeless:	<input type="checkbox"/> Homeless >12 months <input type="checkbox"/> Homeless at least 4 times in the last 3 years
Veteran Status:	<input type="checkbox"/> Honorable <input type="checkbox"/> Dishonorable <input type="checkbox"/> N/A
Household Members:	Adults: _____ Children: _____
<b>*If client is identified to be a vulnerable population, please contact designated agency.</b>	
<i>For all families and chronically homeless individuals contact:</i>	
<i>People Trust Community Housing Program (PTCHP) at 501-404-4857</i>	
Person Contacted: _____	Date and Time: _____
<i>For <b>veteran services</b> contact:</i>	
<i>CAVHS at 501-244-1900 or St. Francis House (SSVF) at 501-916-2514</i>	
Person Contacted: _____	Date and Time: _____

Where did the client/family sleep last night?	<input type="checkbox"/> Shelter	<input type="checkbox"/> Friend/Family's	<input type="checkbox"/> Streets/Car
<input type="checkbox"/> Rental Unit	<input type="checkbox"/> Owns Home	<input type="checkbox"/> 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 Continuum 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.*