GOING HOME HAWAII
Agency Referral Form

EAST HAWAI'I: Phone: (808) 491-2437 | Fax: (808) 498-0315
WEST HAWAI'I: Phone: (808) 464-4003 | Fax: (808) 464-4288

Please check the box beside the program that you are referring your client to:

Rev. 7/25

- ☐ **Pu'uhonua Wellness Center (Hilo – Men's Program)**
- ☐ **Pu'uhonua Wellness Center (Hilo – Women's Program)**
- ☐ **Reentry House (Kona)**
- ☐ **Mentoring Program (Islandwide)**
- ☐ **9 Months: Window of Hope (Pregnant Women ONLY)**
- ☐ **Substance Use Disorder Re-entry Program**

*Note: All of our housing programs are for individuals who are currently on judicial supervision (probation, parole, etc.) and have the income to afford a monthly program fee of $450(Hilo) or $500(Kona). A security deposit is also collected in the amount of $450(Hilo) or $500(Kona). Going Home Hawai'i will screen all referrals for appropriateness for our housing programs and will follow up directly with the judicial supervisor listed as the primary contact at the bottom of this form.

***Note:* Referral sources must agree to provide appropriate support services as needed.**

Client Name:_____ Client Phone Number:_____
Last First MI

Ethnicity: _____ Gender:____ Marital Status:_____Age:____DOB:_____

Currently incarcerated: YES ☐ NO ☐ Location:_____ AO#/SID:_____

Supervising Agency (Parole/Probation/Intake/Furlough):_____ Date of release:_____

Supervising Authority (Ex: Parole/Probation Officer): _____ Phone Number: _____

Probation/Parole/Furlough Until:_____Maxed Out? YES ☐ NO ☐ Sentenced: YES ☐ NO ☐

Emergency Contact:_____ Relationship: _____ Phone Number: _____

Mental Health Issues? YES ☐ NO ☐ Substance Use Disorder? YES ☐ NO ☐ Sex Offender? YES ☐ NO ☐

If released, is client homeless? YES ☐ NO ☐ If yes, date client needs housing: _____

Income Sources (monthly): Employment: $_____ SSDI/SSI: $_____ DHS: $_____ SNAP: $_____

Other: $_____Please explain other income: _____

Debt(s): Legal: $_____ Loan: $_____ Child Support: $_____ Other: $_____ Explain: _____

Is client able to pay program fees? YES ☐ NO ☐ *Monthly Program Fee: $450 (Hilo) **or** $500 (Kona)

Date of last TB test:_____ Result: POS ☐ NEG ☐

9 Months WOH Program ONLY:

Primary Care Physician/OBGYN:_____ Phone:_____ Expected Due Date:_____

_____	_____	_____
Referral Source Name (Print)	Agency or relationship to individual	Phone
_____	_____	_____
Signature	Date	Email

FOR OFFICE USE ONLY

Referral received date:_____ By: _____ Notes:_____