Referral to Family Solutions Centers

Directions: Complete this form and fax or email it to the Family Solutions Center closest to the family's community of origin, the children's school, close to family/friends, etc.

Family Solutions Centers

○ **Valley Oasis - Antelope Valley**
Service Planning Area 1
Email: cesfamilies@avdvc.org
Fax: (661) 942-2079

○ **LA Family Housing - San Fernando Valley**
Service Planning Area 2
Email: referrals@lafh.org
Fax: (818) 982-3895

◉ **Union Station Homeless Services - San Gabriel Valley**
Service Planning Area 3
Email: fscreferral@unionstationhs.org
Fax: (626) 283-5146

○ **PATH - Central Los Angeles**
Service Planning Area 4
Email: familyreferral@epath.org
Fax: (323) 395-5547

○ **St. Joseph Center- West Los Angeles**
Service Planning Area 5
Email: cesreferrals@stjosephctr.org
Fax: (310) 392-8402

○ **SSG/HOPICS - South Los Angeles**
Service Planning Area 6
Email: fsc@hopics.org
Fax: (323) 432-4398

○ **The Whole Child - East Los Angeles**
Service Planning Area 7
Email: FRT@thewholechild.info
Fax: (562) 204-0654

○ **Harbor Interfaith Services - South Bay**
Service Planning Area 8
Email: fscreferrals@harborinterfaith.org
Fax: (310) 684-4031

Family Information

Head of Household Name: _____

Contact Number: _____ Number in Household: _____

Total Monthly Income: _____ Age of Children: _____

Referral Information

Reason for Referral (check only one):

○ Family has identified permanent housing and needs move-in assistance.
◉ Family is literally homeless and in need of assistance with crisis housing and permanent housing.
○ Family must vacate current crisis housing program. Anticipated move-out date: _____
○ Family is imminently at-risk of homelessness.

Reason for Referral to FSC above (check only one):

○ Most geographically relevant FSC based on guidelines above.
◉ Concerns for family safety and well-being necessitate housing in different geographic area. Describe concerns in the 'Additional Information' box below.

Referring Agency Information

Referring Agency: _____ Contact Person: _____

Address: _____ Contact Number: _____

_____ Date of Referral: _____

Agency Type: ☐ Crisis Housing Provider ☐ Social Service Agency ☐ Other (specify): _____

Additional Information

Please provide any additional information such as the current housing plan or special language needs:

FSC Use Only

Date Received: _____ Date/Time of Assessment: _____