Continuum of Care
FAMILY UNIFICATION PROGRAM REFERRAL FORM

Youth/HoH INFORMATION

______________________	____________	______________	_____
Youth/Head of Household Printed Name	Date of Birth	Social Security Number	Gender

I understand that this form will be submitted to the Illinois Department of Children and Family Services (DCFS) and the Housing Authority of Cook County (HACC) for the purpose of the referral to the Family Unification Program (FUP). If the Continuum of Care (CoC) refers me to FUP, this form will be shared with DCFS to review previous DCFS involvement to determine eligibility for FUP. DCFS will also determine if a DCFS contracted service provider needs to offer services to me and, potentially, other household members to meet FUP eligibility requirements. If DCFS determines that I am eligible, DCFS will submit this form to the HACC. I also understand that my signature provides explicit consent to allow DCFS and their contracted provider, the housing authority, the CoC and referral agency to view my date of birth, Social Security number and other personally identifying information. My signature also allows these agencies to discuss services provided to me and household members.

______________________________ ______________________

Youth/Head of Household Signature Date

OTHER ADULTS IN THE HOUSEHOLD

Other Adult in Household (if applicable): I have read and understand the above statement.

______________________________ ______________________

Signature of Other Adult in Household Date

______________________	____________	______________	_____
Printed Name of Other Adult in Household	Date of Birth	Social Security Number	Gender

HOUSEHOLD INFORMATION

Income Source: ____ Amount: ______________

Living Address: ____ Phone: ______________

City/State: ____ Zip Code: ______________

Children's Name (if applicable)	Date of Birth	Gender

____

Youth/Head of Household Printed Name

Does client meet definition of homeless (see 24 CFR 578.3) ☐ Yes ☐ No

Is any person in the household a United States citizen or documented immigrant? ☐ Yes ☐ No

Is the client on the housing authority's Housing Choice Voucher waitlist? ☐ Yes ☐ No

CASEWORKER/SUPERVISOR INFORMATION AND SIGNATURES

Caseworker's Name: ____ Phone: ________________

Agency Name: ____ Fax: ____________________

Address: ____________________________________ City: ______________________________

Supervisor's Name (print): ______________________________________ Phone: ________________

Based on the information that the client has provided, the caseworker believes that this youth and/or family is homeless and meets the initial eligibility requirements for the Family Unification Program.

Caseworker's Signature: ____ Date: __________________

DCFS CERTIFICATION

I, the DCFS Liaison to the Family Unification Program, certify that this client qualifies as a FUP eligible client based on the information provided to me by the caseworker and supervisor.

DCFS FUP Liaison's Signature: Date:

__________________________________ __________________________________