Housing Referral Appeal

Client Name: ____ Date: ______________

HMIS ID #: ____________________________________ Date of Referral: _________________

Housing Program: ____

Case Manager Name: ____

Email: ____ Phone: ___________________

Sending Agency: ____

Sending Agency Case Manager: ____

Email: ____ Phone: ___________________

Reason appealing referral (fill in applicable section)

1. Appealing rejected Return Referral Request

Date of Return Referral Request: _______________________________

Describe why agency disagrees with referral return rejection:

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2. Participant determined not clinically appropriate for program

Please clearly describe reasons for determination and actions taken by sending and receiving agency staff as well as communication with Entry Point Referral Manager:

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Receiving Agency Signature: ____

Date: ____

Submit form to Program Manager at The Alliance to End Homelessness in Suburban Cook County, kurt@suburbancook.org

<table>
<tr><th colspan="3">Appeal Resolution</th></tr>
<tr><td>Appeal Request Accepted</td><td>Yes No</td><td>Date</td></tr>
<tr><td rowspan="6">Members of CE Grievance Committee Votes</td><td>Name</td><td></td></tr>
<tr><td></td><td>Yes No</td></tr>
<tr><td></td><td>Yes No</td></tr>
<tr><td></td><td>Yes No</td></tr>
<tr><td></td><td>Yes No</td></tr>
<tr><td></td><td>Yes No</td></tr>
<tr><td colspan="3">Comments</td></tr>
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