

Homeless Shelter Information Sheet

Homeless shelter name: _____

Address: _____

General phone number: _____

Website (if any): _____

Email address to send patient/client information to: _____

Intake coordinator or other contact person – name(s) and phone number(s), if any: _____

Hours of operation: _____

Client population served:

- Men
- Women
- Youth – specify ages: _____
- Women and children
- Families
- Other – specify: _____

Restrictions?

- No pets
- Must be sober
- Age restrictions – specify: _____
- LGBTQ only
- Domestic violence survivor only
- Human trafficking survivor only
- Veterans only
- Can't accommodate many possessions
- Other – specify: _____

Medical and behavioral health services available: _____

Admission procedures and requirements: _____

Hospital's procedure for homeless patient discharge referrals to this shelter: _____

Date this document was last updated: _____