



HEALTHY HOUSING PROGRAM REFERRAL FORM

Program Eligibility:

- District of Columbia Resident
- Pregnant Woman and/or a Child
≤ 18 Years of Age in Home
- ≥ 1 Housing-Related Concerns

Referral Date: _____

Referred By:

Name: _____
 Agency: _____
 Phone: _____
 Email: _____

BASIC DEMOGRAPHIC & CONTACT INFORMATION

Child Name: _____

Mark circle if client is a Pregnant Woman without children currently in the household (*Specify her name as Parent/Guardian*)

Child Date of Birth: _____ **Child Gender:** M / F

Parent/Guardian Name: _____ **Email:** _____

Home Phone Number: _____ **Alternate Phone Number:** _____

Home Address: Street: _____ **Zip Code:** _____

HOUSING CONCERN(S): (*Check all that apply and specify severity*)

	Minor Issue		Moderate Issue		Severe Issue
<input type="radio"/> Chipping/Peeling Paint	1	2	3	4	5
<input type="radio"/> Mold	1	2	3	4	5
<input type="radio"/> Water Damage/Leaks	1	2	3	4	5
<input type="radio"/> Pests (Insects/Rodents)	1	2	3	4	5
<input type="radio"/> Excessive Household Dust	1	2	3	4	5
<input type="radio"/> Renovation/Structural Concerns	1	2	3	4	5

List the names and ages of additional children in the household if applicable: _____

Other information you believe is important for us to know about this household: _____

