



FOR MORE INFORMATION, CONTACT
DANIEL ROBINSON AT 313-645-6507 OR
COMMUNITYPROGRAMS@MCHSMI.ORG.

Please complete form and email to W.A.R Program staff member. All sections and items on this form are required to be considered a complete referral. Any forms not completed in their entirety will not be reviewed.

Referring Agency Information

Referring Agency: _____ Date: _____
Caseworker Name: _____ Title: _____
Phone Number: _____ Email: _____
Fax: _____

Requested Assistance Details

- | | | |
|--|---|--|
| <input type="checkbox"/> Personal Identification | <input type="checkbox"/> Interview/Work clothes | <input type="checkbox"/> Transportation assistance |
| <input type="checkbox"/> Housing Assistance | <input type="checkbox"/> Education Assistance | <input type="checkbox"/> Employment Assistance |
| <input type="checkbox"/> Furniture Assistance | <input type="checkbox"/> Utility Assistance | <input type="checkbox"/> Driver License Assistance |
| <input type="checkbox"/> Other _____ | | |

Referred Client Information

Do they have an open case file with your agency? Yes No

Do they have an assigned case manager with your agency, coordinating services? Yes No

Name: _____ Date of Birth: _____
County: _____ Phone Number: _____
Probation term: _____ Parole term: _____

Case Description