



Havaras Group LLC
New Beginnings Housing
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ORGANIZATION REFERRAL FORM

Referring Organization Name: _____

Program / Department Name: _____

Staff Contact Name & Title: _____

Phone Number: _____ Email: _____

Client Full Name: _____

Date of Birth: _____

Current Housing Status: Homeless Shelter Transitional Other _____

Primary Income Source (SSI, SSDI, VA, SSA, Other): _____

Approximate Monthly Income: _____

Does the client manage daily living independently? Yes No

Does the client require 24-hour medical or nursing care? Yes No

Is the client able and willing to follow house rules (no drugs, no visitors, shared living)? Yes No

Any behavioral, safety, or housing concerns staff should note:

How soon does the client need housing? Immediate Within 30 days Flexible

Referring Staff Signature: _____ Date: _____

Submission Instructions: Please return this completed referral form by email to info@havarasgroupplc.com. A representative from New Beginnings Housing will contact the applicant and/or referring organization to schedule an in-person interview.