****

SPD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Housing Stabilization Services (Transitioning & Sustaining) Referral Form***

**Today’s Date:**

**Name of Referral:**

**Is this person able to meet virtually if needed?  Yes  No – If no, what are the barriers?**

**Required with this completed referral form**

**1) One of the following person centered planning options (check the included document):**

Housing Focused Person Centered Plan (DHS-7307)

Coordinated Services and Supports Plan (Case Manager)

Coordinated Care Plan (Senior Care Coordinator)

**2) Proof of housing instability/assessed need for services (check the included document):**

Professional Statement of Need (DHS-7122)

MN Choices Assessment

Long Term Care Consultation

DHS HSS Coordinated Entry Assessment/Document

**3) Proof of disability (check the included document):**

Professional Statement of Need (DHS-7122)

Proof of Age 65 or older (please check if applicable – do not need to provide proof)

SMRT Approved Letter

Medical Opinion Form (DHS-2114)

MA-DX/MA-BX/MA-EPD (please check if applicable – do not need to provide proof)

**If also approving Transitional Services based on waiver eligibility, please complete:**

* **Has this person received Transitional Services in the past 3 years?**  **Yes**  **No**
* **Services identified/needed:**  **Assistance coordinating/setting up the move**  **Household Items/Furniture**

**Application Fee**  **Damage Deposit**

**Current Living Situation (please check appropriate box):**

Own housing: lease, mortgage or roommate Service Provider: Foster care, group home Emergency Shelter

Jail/prison/juvenile detention Declined to answer Hospital/Treatment/Detox/Nursing Home

Family/friends due to economic hardship Hotel/Motel  Place not meant for housing

**Current Level of Housing Instability (please check appropriate box):**

Homeless  At-Risk of Homelessness  Transitioning from Facility  Institution Level of Care/Eligible for Waiver

**Disability Type (please check appropriate box(s):**

SSI/SSDI  Developmental Disability  Substance use disorder  Injury or illness with extended incapacitation  Mental illness  Learning disability

**PMI/MA #:**

**Current County or Tribal Location of Residence:**

**Current Address:**

**Current Phone:**

**Current Email:**

**Potential challenges/barriers to finding housing?**

**What City/Area(s) is the consumer interested in moving to?**

**Are there currently any animals living in the home of this referral?**  **Yes**  **No**  **Unsure**

**If Yes, identify:**

**Current source(s) and amount(s) of income (SSI, SSDI, Wages, etc.):**

**Date of Birth:**

**Identified Gender:**  **Male**  **Female**  **Other**

**Case Manager/Care Coordinator/Housing Consultation Provider - Name:**

* **Phone Number:**
* **Email:**

**Own Guardian/Legal Representative:**

**Yes**

**No - Guardian/Legal Representative Name:**

**Phone Number:**

**Email:**

**Other Information that would assist in providing services to the above named individual:**