****

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:**