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Housing Stabilization Services (Transitioning & Sustaining) Referral Form

Today's Date:

Name of Referral: **PMI:**

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

Does this person utilize CDCS? **Yes** **No**

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 Plan Care Coordinator)

2) One of the following person centered planning options (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)

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)

4) Does your client qualify for moving expenses through HSS?

If yes: please select applicable statement below:

- Moving from a Medicaid (MA) institutional setting
- Leaving a provider-controlled setting (foster care, customized living, assisted living, individual community supports, supportive housing, housing supports, temporary housing
- Is currently homeless and have stayed in a shelter at some point over the last 12 months

5) If your client does not qualify for HSS moving expenses and you are seeking 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 Damage Deposit

5) Current Status of Consumer

Stable Income

Currently in stable housing

Previous evictions/Felonies

Emergency Housing Needed

Revised: 12/28/22

6) 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

7) Current Level of Housing Instability:

Homeless   At risk of homelessness   Transitioning from facility   Institution Level of Care/Eligible for waiver

8) Disability type (Please check Appropriate Box):

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

Mental Illness   Learning Disability

9) Other consumer information:

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?

If Yes, identify type:

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:

Phone Number   **Email:**

Own Guardian:

Yes   **No - Guardian/Legal Representative name:**

Phone:

Email:

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