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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)

2) One of the following Assessment Types (check the included document):

   Professional Statement of Need (DHS-7122)

   MN Choices Assessment or 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: 6/6/24

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:

Disclaimer: If the client finds housing independently while they are being processed for DHS approval for Housing Stabilization Services or is on our waiting list, we are not able to guarantee staff availability for transitional waiver services. Pending staff availability, there may be a waiting period prior to being assigned a staff member to address transitional waiver service/moving expense needs.