2022 Housing Stabilization Services (Transitioning & Sustaining) Referral Form

Date Submitted:

Client Information

Client Name PMI Date of Birth
Address City State MN Zip Code County
Phone Email

Case Manager Information

Name Phone Email

Guardian/Legal Representative/Support Person Information (if applicable)

Name Phone Email
Relation to Client

Is client able to meet virtually if needed? ☐ Yes ☐ No – What are the barriers?

Required with this completed referral form

1) 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)

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) 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)

4) Copy of Medical Assistance card

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

Potential challenges/barriers to finding housing?

What City/Area(s) is the client 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.):

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