
**Housing Stabilization Services (HSS) Referral Form** **Date:**

Referring County Staff: _____ Referring County: _____

Phone: _____ Fax: _____

**NPI#**: A254695100

Start Date: _____ End Date: _____

NAME: _____ DOB: _____ SEX: ___
FIRST MI LAST M/D/YEAR

ADDRESS: _____
STREET CITY ZIP CODE COUNTY

SOCIAL SECURITY: _____ PMI#:_____

PH: _____ EMAIL: _____

WHERE DOES THE INDIVIDUAL CURRENTLY LIVE (if different from above address)?

_____
ADDRESS (STREET, CITY, ZIP, COUNTY)

**WAIVER TYPE:**

BRAIN INJURY (BI) ☐Yes ☐No

COMMUNITY ALTERNATIVE CARE (CAC) ☐Yes ☐No

COMMUNITY ACCESS FOR DISABILITY INCLUSION (CADI) ☐Yes ☐No

DEVELOPMENTAL DISABILITIES (DD) ☐Yes ☐No

**DIAGNOSIS CODE FOR HOUSING STABILIZATION SERVICES:**

DEVELOPMENTAL DISABILITY: ☐ LEARNING DISABILITY: ☐

MENTAL ILLNESS: ☐ PHYSICAL ILLNESS, INJURY OR IMPAIRMENT: ☐

CHEMICAL DEPENDENCY: ☐

**CLIENT INSURANCE PROVIDER (Medica, Hennepin Health, Health Partners, etc.):**

_____

GROSS INCOME: _____ SOURCES: _____

MINNESOTA RESIDENT ☐ Yes ☐ No
IF NO, WHERE?: _____

MN ID: ☐ Yes ☐ No SOCIAL SECURITY CARD: ☐ Yes ☐ No

CRIMINAL RECORD: ☐ Yes ☐ No

PLEASE LIST: _____

ANY UNLAWFUL DETAINER (UD) ☐ Yes ☐ No

PLEASE SPECIFY REASON: _____

SMOKER: ☐ Yes ☐ No

SUPPORT NETWORK/FAMILY CONTACT INFO

_____ _____

_____ _____

_____ _____

**MEDICAL CONCERNS:**

| |
|---|
| |


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**IMPORTANT NOTES:**

(If changing agencies please also indicate the stage and units available.)