**Legacy HOUSING STABILIZATION SERVICES REFERRAL FORM**

\*Referral Form must be completed in full\*

Referral Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal Information**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| First Name: | | | M.I.: | Last Name: | | |
| Date of Birth: | Gender: Male Female  Prefer not to answer  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Race: | | SSN: |
| Address: | | | | City: | | Zip code: |
| Phone Number: | | Cell Number: | | | E-mail address: | |

**Primary Emergency Contact Information**

|  |  |
| --- | --- |
| First name: | Last name: |
| Best Contact Number: | Relationship: |

**Special Needs**

|  |
| --- |
| Are there any known cultural consideration needs? Yes No specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Is there any gender preference regarding the assigned staff? Yes No If yes: Male Female No preference  Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other (be specific): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Diagnostic Code and Description** (mental health and physical health): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PMI Number** (MA only): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Level of Need**

|  |
| --- |
| Does this person have a criminal background? Yes No  Are you aware of any drug/ alcohol use? Yes No  Does this person use the following? (mark all that apply) Walker Cane Wheelchair  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Does this person have an income source? Yes No **(If yes, enter information below)**  Type of income: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Type of income: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Type of income: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Type of income: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Does this person currently have a lease? Yes No  If so, when will it end? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Is this person currently homeless or will be homeless? Yes No  If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| How soon does this person want to move? (exact date not necessary) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How soon will this person need to move? (exact date not necessary) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Is this person best described as **actively** looking for housing or **passively** looking for housing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other important notes (please be specific): |

**Care Preferences**

|  |
| --- |
| How many days **per week** does the Case Manager want us to provide HSS Services to this person?  0 1 2 3 4 5 6 7  How many units **per week** does the Case Manager expect to be used for this person? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ units |
| Housing search preferences (mark all that apply): Market Housing Income-based Housing  Supportive Housing Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Will this person need Transitional Services? (choose all that apply)  Deposit Movers Household items Furniture |

**Legal Status & Legal Representative Contact Information**

|  |  |  |
| --- | --- | --- |
| responsible for self under guardianship **(complete section below)**  under commitment | | |
| First name: | Last name: | |
| Address: | City: | Zip code: |
| Best Contact Number: | Fax Number: | Email: |

**Waiver Case Manager Information**

|  |  |  |
| --- | --- | --- |
| First Name: | Last Name: | |
| Address: City: Zip code: | | |
| E-mail Address: | | |
| Office number: | Office Fax: | Office number: |
| Agency Name: | Would you like to be updated on all assessment scheduling ? Yes No | |

PLEASE BE ADVISED: If this person fails to respond to HSS Specialists on 3 or more

occasions in a month, a 30-day termination notice will be served.

Case Manager Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legacy Housing Services LLC

1518 E Lake St, Minneapolis, MN, 55407

Phone Number: 763-3406082

Referral Email: legacyhousingservices@outlook.com