277 Coon Rapids Blvd, Suite 115 Coon Rapids MN 55433
Phone: 612-842-9200 **Fax:** 612-545-2876
Email: info@virtuouscommunityservices.com
NPI # A827648500

HOUSING STABLIZATION SERVICES: ELIGIBITY REQUEST

INITIAL OR RENEWAL FORM

Date of Referral:

REFERRING AGENCY:

NPI/UPMI:

NAME AND TITLE:

PHONE: EMAIL ADDRESS: FAX:

Referral Request: (Select One):

- ☐ Initial Eligibility
- ☐ Provider Change
- ☐ Renewal Eligibility
- ☐ Consultation
- ☐ PCPlan Change

Additional Types of Request:

- ☐ Authorization Change from Transition to Sustaining
- ☐ Authorization Change from Sustaining to Transition

RECIPIENT INFORMATION:

FIRST NAME:

LAST NAME:

DATE OF BIRTH:

PHONE NUMBERS:

EMAIL:

PMI #:

SOCIAL SECURITY#:

MAILING ADDRESS: UNIT #:

CITY: STATE: ZIPCODE:

COUNTY/TRIBE LOCATION:

RECIPIENT STATUS:

LIVING SITUATIONS: **[one required]**

- ☐ Own Housing: Lease, Mortgage or Roommating
- ☐ Service Provider: Foster Care, Group Home
- ☐ Jail/Prison/Juvenile Detention
- ☐ Emergency Shelter
- ☐ Declined
- ☐ Family/Friends Due to Economic Hardship
- ☐ Hospital/Treatment/Detox/Nursing Home
- ☐ Hotel/Motel
- ☐ Place Not Meant for Housing

Please provide essential details of current living situation & notes to best support the referral:

RECIPIENT STATUS (Cont.):

HOUSING STATUS: **[one required]**

- ☐ TRANSITIONING
- ☐ SUSTAINING

HOUSING INSTABILITY: **[one required]**

- ☐ HOMELESS
- ☐ AT-RISK FOR HOMESLESSNESS
- ☐ TRANSITIONING FROM A FACILITY
- ☐ INSITUATIONAL LEVEL OF CARE/ELIGIBILE FOR WAIVER

DISABILITY TYPE: **[one required]**

- ☐ SSI/SSDI ELIGIBLE
- ☐ INJURY OR ILLNESS WITH EXTENDED INCAPACITATION
- ☐ DEVELOPMENTAL DISABILITY
- ☐ MENTAL ILLNESS
- ☐ SUBSTANCE USE DISORDER
- ☐ LEARNING DISABILITY

CONSULTATION STATUS, if applicable

AGENCY NAME: NPI:

FIRST NAME: LAST NAME:

ADDRESS: ZIP CODE: COUNTY OR TRIBAL LOCATION:

PHONE NUMBER EXTENSION: FAX NUMBER:

EMAIL ADDRESS:

Eligibility documents, to be submitted with the referral:

1. **PROOF OF DISABILITY TYPE [only one required]**

- ☐ PROFESSIONAL STATEMENT OF NEED-PSN
- ☐ STATE MEDICAL REVIEW TEAM (SMRT) DETERMINATION LETTER
- ☐ MA-DX/MA-BX
- ☐ SOCIAL SECURITY AWARD STATEMENT (SSI/RSDI/SSDI)
- ☐ MEDICAL OPINION FORM
- ☐ AGE 65-YEARS OR OLDER

2. **ASSESSMENT TYPE [only one required]**

- ☐ PROFESSIONAL STATEMENT OF NEED-PSN (Non-Waiver)
- ☐ COORDINATED ENTRY ASSESSMENT
- ☐ MnCHOICES ASSESSMENT (Waiver)
- ☐ LONG TERM CARE CONSULATION (LTCC)

3. **PERSON-CENTNERED PLAN TYPE [only one required]**

- ☐ HOUSING-FOUSED PERSON CENTERED PLAN (PCP) (Non-Waiver)
- ☐ COORDINATED SERVICES AND SUPPORTS PLAN (CSSP)(Waiver)
- ☐ COLLABORATIVE/COMPREHENSIVE CARE PLAN (CCP) (Elderly Waiver)

4. **OTHER SUPPORTING DOCUMENTS (optional, yet supportive)**

- ☐ FACESHEET