Referral to Housing Stablization Services (HSS)

COMMUNITY OUTREACH SERVICES LLC
We Value Our Clients

Referring County Staff:_____**Referring County:**_____

Email:_____

Phone:_____ **Fax:**_____

Name:_____ DOB:_____Sex:_____
First Middle Last

Address:_____
Street City Zip Code County

SSN:_____PMI:_____Phone:_____

Email:_____

WHERE DOES THE INDIVIDUAL CURRENTLY LIVE? (If diffent from address)

Address:_____
Street City Zip Code County

Waiver Type:

Brain Injury (BI) _____Yes _____ No
Community Alternative Care (CAC) _____Yes _____ No
Community Access For Disability Inclusion (CADI)_____Yes _____ No
Developmental Disability (DD) _____Yes _____ No

Gross Income:_____ Sources:

Minnesota Resident:_____Yes _____ No
If no, where?_____

MN ID:_____Yes _____ No Social Security Card:_____Yes _____ No

Criminal Record:_____Yes _____ No

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Unlawful Detainer (UD) _____Yes _____ No

Please specify reason:

Smoker:_____Yes _____ No

Support Network/Family	Contact Info
1._____	_____
2. _____	_____
3._____	_____
4. _____	_____

Medical Concerns:

Diagnosis Code:_____

Check documents submitted to MN-DHS

MNChoicesor Professional Ststement of Need _____Yes _____ No
Coordinated Entry Assesment _____Yes _____ No
Medical Opinion Form _____Yes _____ No
MA-BX (Blind), MA-DX or SSI/SSDI recipient award letter _____Yes _____ No
Person Centered Plan - Community Service and Support Plan (CSSP) _____Yes _____ No
Coordinated Care Plan (CCP) seniors 65+ _____Yes _____ No
Housing - Focused Person - Centered Plan _____Yes _____ No

Check documents submitted to HSS Provider - Community Outreach Services LLC

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