SunnySkyHC

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): _____

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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

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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 our Specialists on 3 or more occasions in a month, a 30-day termination notice will be served.

At time of referral, you may submit any other supporting documents (if you have them available):
**CSSP Or CCP *If the client is not on a waiver obtain a professional statement of need (DHS 7122) signed by a qualified professional.*

Case Manager Signature: _____ Date: _____

SunnySkyHC
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