BRIGHT HORIZON THERAPY CENTER INC

**HOUSING STABILIZATION SERVICES REFERRAL FORM**

\*Referral Form must be completed in full before **BHTC** can process referral\*

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 & treatment of services?  Yes  No | |

**PLEASE BE ADVISED:** If this person fails to respond to **BHTC** **HSS** 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):***

*\*Most current Diagnostic Assessment \*Copy of Functional Assessment / LOCUS \*County Case Plan*

*\*Crisis Plan \*etc.*

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

***Referrals and copies of documents can be mailed, faxed, or e-mailed to:***

***BRIGHT HORIZON THERAPY CENTER INC***

***5245 EDINA INDUSTRIAL BLVD***

***EDINA, MN 55439***

***Fax: (952) 960-0137 Attn: Sahra Hassan***

***E-mail:******info@brighthorizonmn.net Subject: HSS Referral Form***