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 preferenceAllergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_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 [ ]  NoAre you aware of any drug/ alcohol use? [ ]  Yes [ ]  NoDoes 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 [ ]  7How 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***