Housing Stabilization Services

Referral Date: _____

Personal Information:

Full Legal Name: _____ Date of Birth: _____

Gender/Preferred Pronouns: _____ Phone Number: _____

Address: _____ Email Address: _____

City, State, Zip: _____ SSN: _____

PMI Number: _____ Economic Assistance Case Number: _____

Preferred Language: _____ Interpreter Needed (Y/N): _____

Emergency Contact Information:

Name: _____ Relationship to Client: _____

Address: _____ Phone Number: _____

City, State, Zip: _____ Email Address: _____

Preferred Language: _____ Interpreter Needed (Y/N): _____

Legal Status & Legal Representative Contact Information:

☐Responsible for Self

☐Guardian/Power of Attorney/Health Care Directive Agent **(Complete Section Below)**

Name: _____ Relationship to Client: _____

Address: _____ Phone Number: _____

City, State, Zip: _____ Email Address: _____

Preferred Language: _____ Interpreter Needed (Y/N): _____

Case Manager/Care Coordinator Contact Information:

Name: _____ Title: _____

Agency: _____ Phone Number: _____

Fax Number: _____ Email Address: _____

Financial Worker Contact Information:

Financial Worker Name: _____ Phone Number: _____

County of Financial Responsibility: _____ Fax Number: _____

Email Address: _____

Insurance Information:

☐Medical Assistance ☐Medica ☐UCare ☐HealthPartners

☐Blue Cross ☐ IMcare ☐ South Country ☐ Other: _____

How Soon Does the Person Served Need to Move?

Required Documentation to Submit for HSS:

Proof of Disability Type (Only one document needed from this category):

- ☐ Professional of need
- ☐ State medical review team statement showing MA DX or MA-EPD
- ☐ SSI or SSDI Eligible
- ☐ Medical Opinion Form
- ☐ Proof of being Aged 65 Years or Older
- ☐ Other (Coordinated Plan if it shows proof of their disability)

Assessment Type (Only one document needed from this category):

- ☐ Professional Statement of Need
- ☐ Coordinated Entry
- ☐ MnChoices Assessment or LTCC

Person-Centered Plan Type (Only one document needed from this category):

- ☐ Housing Focused Person-Centered Plan
- ☐ CSSP or Coordinated Care Plan

***Please Submit Referral Form & Request Documentation to: HSSReferrals@ilpmn.com**