REFERRAL FOR HOUSING STABILIZATION SERVICES (HSS)

Please attach Professional Statement of Need (PSN)

Referring Staff Name and Title: ____

Referring County: ________________________ Phone Number: ___________________________

Email: ____

Client name: __________________________________ Birth date: ____________ Gender: ____

Current address: ____

City: ____ State: ___________ Zip: ________

Phone: ____________________ Social Security #: ______________ PMI: __________________

Email: ____

Waiver type (circle any that apply):

Brain Injury (BI) Community Alternate Care (CAC) Elderly Waiver (EW)

Community Access for Disability Inclusion (CADI) Developmental Disability (DD)

Income: ________________ Source: ____

Income: ________________ Source: ____

Income: ________________ Source: ____

SNAP / food stamp amount: __________________

Smoker: Yes or No Criminal record: Yes or No Evictions or unlawful detainers: Yes or No

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