OASIS HOUSING SERVICES
REFERRAL FORM

Referral Form must be completed in full before MCHS 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): _____

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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: _____

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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:
Email Address:		
Office number:	Office Fax:	Office number:
Agency Name:	Would you like to be updated on all assessment scheduling & treatment of services? ☐ Yes ☐ No	

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)

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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 BE ADVISED: If this person fails to respond to MCHS 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:

Housing Stabilization Services (HSS) Referral Form
Oasis Housing Services LLC
1518 E. Lake St, 201B
Minneapolis, MN 55407
Phone: 612-806-3815
ATTN: Ifrah Ali
NPI#: A755402100
Email: oasishousingservicesllc@gmail.com