BestSelf Housing Referral Form (Complete Front page only)

Referral Date: _____ Referrer Name: _____

Phone Number: _____ Agency/Program: _____

Cerner# _____ HMIS# _____

Name: _____ Phone #: _____

DOB: _____ Age_____ SS#: _____

Race: _____ Income Source/Amount: _____

Gender: _____ Orientation: _____ Veteran: ☐ Yes ☐ No

Marital Status: _____ Number of Children: _____ # Children in Custody: _____

Gender/Age of Individuals to be Housed: _____

Medicaid CIN#: _____ Managed Care Organization: _____

Care Coordination Status: Health Home ☐   ACT ☐   AOT ☐

Current Address: _____ County: _____

Homeless at: Street ☐   Shelter ☐   DSS Hotel ☐   Hospital ☐   Uninhabitable ☐

Current Reason/Length of time: _____

At Risk of Homelessness/Reason: _____

Eviction ☐ Substandard ☐ Overcrowded ☐ Recovery ☐ Unaffordable ☐ Inpatient Discharge ☐

Homeless History (List episodes and dates in past 12 months) **Chronically Homeless:** ☐ Yes ☐ No

ER Visits (List facilities and dates in past 12 months)   **Total ER Visits:** _____

Inpatient/Rehab Hospitalizations (List facilities and dates in past 12 months) **Total Inpatient:** _____

Diagnosis (List all mental health, substance use, medical and physical)

Medications

Legal Status and History

Certification of Program Eligibility (Completed by BestSelf Housing Staff only)

Qualifying Diagnosis   (Verification documentation received) ☐

☐ Substance Use Disorder _____

☐ Severe Mental Illness _____

☐ Other Disability _____

Medicaid Utilization   (PSYCKES, HEALTHeLINK documentation or rehab discharge received) ☐

☐ Have two or more inpatient stays;

☐ Have five or more emergency department visits;

☐ Have four or more emergency department visits and one or more inpatient stay;

Enrolled in: Health Home ☐   ACT ☐   AOT ☐

☐ Enrolled in: Medicaid

☐ Individual

☐ Family (An eligible individual that has legal custody of a child or children under the age of 18)

Homeless Certification   (Homeless verification documentation received) ☐

☐ Homeless: Individuals or families that are either living on the street, in a shelter or a hospital or has more than three addresses in the past 12 months.

☐ At Risk of Homelessness: Reason _____

☐ Accepted to BestSelf Housing Program: _____   Date Accepted _____

Supervisor Signature: _____

Assigned to: _____   Date: _____

```
[                                                                    ]
[                                                                    ]
[                                                                    ]
```

☐ Admitted to BestSelf Housing Program   Date Admitted _____

Referral Disposition

Reason Not Accepted to BestSelf Housing Program: Date Rejected _____

☐ Client refusing program services

☐ Client does not meet program criteria. Reason _____

☐ Client not homeless, referred to _____

☐ Loss of contact with client

```
[                                                                    ]
[                                                                    ]
[                                                                    ]
```