Independent Management Services

Providing Human Services to Families in Southern Minnesota

Housing Stabilization Services Referral Form

Email: info@imsofmn.com | Fax: (507) 437-0977

* Please included signed release of information if applicable *

Date of Referral: _____

Client Information

Name: _____ DOB: _____

Mailing Address: _____

Phone: _____ Email: _____

Does client have Medical Assistance: ☐ YES ☐ NO

Housing instability: ☐ Homeless ☐ At-risk for homelessness ☐ Transitioning from an institution
☐ At-risk for institutionalization AND receives waivered services

Current living situation: ☐ Own Housing: lease, mortgage, or roommate ☐ Friends/Family due to economic hardship
☐ Service Provider: Foster Care, group home ☐ Exiting jail/prison/juvenile detention
☐ Hospital/treatment/detox/nursing home ☐ Hotel/Motel ☐ Place not meant for housing

Disabling condition (check all the apply): ☐ Developmental Disability ☐ Injury/Illness with extended incapacitation
☐ Learning Disability ☐ Mental Illness ☐ Substance Use Disorder

Requires assistance with (check all that apply): ☐ Mobility ☐ Decision making ☐ Communication
☐ Managing challenging behaviors

Does client have any of the following (check all that apply): ☐ Targeted Case manager ☐ Waiver Case Manager
☐ MSHO/MSC+ Care Coordinator

Referral Source Information

Name/Agency: _____ Relationship to client: _____

Phone: _____ Email: _____

Is client aware of referral being made: ☐ YES ☐ NO

Please list any known professional supports and/or any additional pertinent information:

_____

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