**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

Click here to enter text.

**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:**

Click here to enter text.

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

Click here to enter text.

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

Click here to enter text.

**Medications**

Click here to enter text.

**Legal Status and History**

Click here to enter text.