**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.