CAREMARK
Home Health Care
Care You Can Trust

HOUSING STABILIZATION SERVICES REFERRAL FORM
NPI No: 1407476252

Referral Form must be completed in full

Referral Date: ___________________

Personal Information

First Name:	M.I.:	Last Name:	PMI No:
Date of Birth:	Gender: Male Female Prefer not to answer Other: _______________	Race:	SSN:
Address:		City:	Zip code:
Phone Number:	Cell Number:	E-mail address:	
Diagnosis Codes			

Primary Emergency Contact Information

First name:	Last name :
Best Contact Number:	Relationship:

Special Needs

Are there any known cultural consideration needs? Yes No specify: ________________________________

Allergies: ____

Other (be specific): ____

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: $_______________

Caremark Home Health Care LLC
Email: Caremarknursing@gmail.com Phone: 612-399-9987 Fax: 952-487-4284

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: ____________________

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:

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Waiver Case Manager Information

First Name:	Last Name:	
Address:	City:	Zip code:
E-mail Address:		
Office number:	Office Fax:	Office number:
Agency Name:	Would you like to be updated on all assessment scheduling ? ☐ Yes ☐ No	

<u>PLEASE BE ADVISED:</u> If this person fails to respond to CAREMARK 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: _______________

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