Region 4 Housing Referral

Staff:	Date:
CSB/BHA:	Hospital:
Email:	Phone:

Consumer's Name: _____

Support Systems/AR/Legal Guardian: _____

Consumer's DOB: _____

Consumer's Benefits:

☐ Private Insurance ☐ Medicaid ☐ Medicare (please list types) ☐ Other

_____

Consumer's Income Benefits:

☐ SSI $_____ ☐ SSDI $_____ ☐ SSA $_____ ☐ Other $_____

Income Benefits Status: ☐ Active ☐ Pending ☐ Suspended ☐ App. Submitted

Auxiliary Grant Eligible: ☐ Yes ☐ No ☐ Unknown

ID/DD Diagnosis: ☐ Yes ☐ No ☐ Waiver Status: _____

Previous Housing: _____

Type of Housing Request (IL, ALF, NH, Waiver Home, Memory Care, etc.):

_____

_____

List of Declined Housing: _____

_____

Current Behaviors/Barriers: _____

_____

Special needs/care required (i.e. wheelchair, medical, etc.):

_____

_____