NAFRIM GROUP SERVICES LLC
Connecting Solutions, Elevating Success

6695 93rd Alcove S Cottage Grove, MN 55016
info@nafrimgroupservices.com / nafrimgroup@gmail.com
www.nafrimgroupservices.com
Contact: 651-318-7219

# NAFRIM GROUP SERVICES LLC
# HOUSING STABILIZATION SERVICES REFERRAL FORM

*Referral Form must be completed in full before NGS can process referral*

Referral Date: _____

**Personal Information**

| | | | |
|---|---|---|---|
| First Name: | M.I.: | Last Name: | |
| Date of Birth: | Gender: ☐ Male ☐ Female ☐ Prefer not to answer ☐ Other: _____ | Race: | SSN: |
| Address: | | City: | Zip code: |
| Phone Number: | Cell Number: | E-mail address: | |

**Primary Emergency Contact Information**

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

**Special Needs**

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

Is there any gender preference regarding the assigned staff? ☐ Yes ☐ No If yes: ☐ Male ☐ Female ☐No preference

Allergies: _____

Other (be specific): _____

**Diagnostic Code and Description** (mental health and physical health):
_____

**PMI Number** (MA only): _____

**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: $_____
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)<br>☐ 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: |

**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 & treatment of services? ☐ Yes ☐ No | |

**PLEASE BE ADVISED:** If this person fails to respond to NGS 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: _____

Referrals and copies of documents can be mailed or e-mailed to:
NAFRIM GROUP SERVICES LLC
6695 93RD ALCOVE S,
COTTAGE GROVE, MN 55016
E-mail:nafrimgroup@gmail.com
OR
E-mail: info@nafrimgroupservices.com