# HOUSING FACILITATION REFERRAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES
AGING SERVICES
SFN 1202 (4-2023)

Clear Fields

| Name of Client | | | Date of Birth | |
|---|---|---|---|---|
| Address | | City | State | ZIP Code |
| Client Gender ☐ Male ☐ Female | Client Phone Number | Date of Referral | Monthly Income | |

Insurance
☐ MA ☐ MA Pending ☐ Medicaid Expansion ☐ Medicare ☐ Other (specify):

| Person Making Referral | Referral Phone Number |
|---|---|
| Desired Community to Live In | |

Reason for Housing Referral (check all that apply)

| | | |
|---|---|---|
| ☐ Requesting a Reasonable Accommodation | ☐ Deposit | ☐ Pending Eviction |
| ☐ Housing Modification | ☐ Accessibility | ☐ Low Credit Score |
| ☐ Limited Income | ☐ Criminal Background | ☐ ND Rent Help |
| ☐ Rent | ☐ Eviction on Record | ☐ Assistance in Navigating System |
| ☐ Other (specify): _____ | ☐ Porting a Voucher | ☐ Applying for Weatherization/RAP Grant |

Services Receiving (check all that apply)

| | | |
|---|---|---|
| ☐ Transition Coordination | ☐ HCBS | ☐ North Dakota State Hospital Transition |
| ☐ Behavioral Health Case Management | ☐ DD Program Management | ☐ Adult Protective Services |
| ☐ Other (specify): _____ | ☐ Community Service Coordination | ☐ Vocational Rehabilitation |

| Does this person have a significant disability? ☐ No ☐ Yes | Disability/Condition |
|---|---|

What major life activities are limited by disability? (Check all that apply)
☐ Breathing ☐ Talking ☐ Walking ☐ Hearing ☐ Seeing ☐ Sleeping ☐ Caring for Oneself ☐ Working
☐ Performing Manual Tasks ☐ Other (specify): _____

| Does this person have a legal decision maker? ☐ No ☐ Yes-Name of Legal Decision Maker: | Phone Number |
|---|---|

Legal Decision Maker Type
☐ Guardian ☐ Durable Power of Attorney for Healthcare ☐ Durable Power of Attorney for Finance ☐ Durable Power of Attorney
☐ Supported Decision Maker ☐ Other (specify): _____

**Internal Office Use Only**

| Date Referral Received | Approved ☐ No ☐ Yes | Date Approved/Denied |
|---|---|---|
| Reason Denied | | |
| MFP Staff Signature | | Date Assigned in Therap |