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| **INTERAGENCY HSP REFERRAL FORM** | | | | | | |
|  |  | |  | |  | |
| **This Interagency referral may be initiated by ODHS or by a CAA to refer clients for HSP services – it does not replace personal contact.** | | | | | | | |
| **F**  **R**  **O**  **M** | Agency | | | | Referring Person (electronic sign) | Date | |
| Click here to enter agency. | | | | Click here to enter name. | Pick date. | |
| Office | | Phone | | Address | Email | |
| Enter office. | | Enter phone. | | Enter address. | Enter email. | |
| **T**  **O** | Agency | | Phone | | Agency Contact Person | | |
| Enter agency. | | Enter agency. | | Enter agency. | | |
| **C**  **L**  **I**  **E**  **N**  **T** | Client Name | | DOB | | Preferred Language, if not English | Phone | |
| Enter name. | | Enter DOB . | | Enter language. | Enter phone | |
| Address | | City | | State | Zip | |
| Enter address. | | Enter city. | | OR | Enter zip | |
| Case Name (if different) | | | | Case Number | | |
| Enter name, if different. | | | | Enter case number. | | |
| Referring Agency Confirms: | | | | | | | |
| Literally Homeless Unstably Housed Refugee Teen Parent | | | | | | | |
| INCOME: TANF Recipient Not TANF, but income below 150% FPL Not TANF, but income between 151%-250% FPL | | | | | | | |
| If receiving TANF, what is the TANF monthly grant amount: $ Enter TANF Amount. | | | | | | | |
| Number of persons in Household: | | | Enter # in HH. | | List household members below and relationship to client | | |
| **Name** | | | **Relationship** | | **DOB** | **SSN** | |
| Enter name. | | | Enter relationship. | | Enter DOB. | Enter SSN. | |
| Enter name. | | | Enter relationship. | | Enter DOB. | Enter SSN. | |
| Enter name. | | | Enter relationship. | | Enter DOB. | Enter SSN. | |
| Enter name. | | | Enter relationship. | | Enter DOB. | Enter SSN. | |
| Enter name. | | | Enter relationship. | | Enter DOB. | Enter SSN. | |
| Enter name. | | | Enter relationship. | | Enter DOB. | Enter SSN. | |
| Enter name. | | | Enter relationship. | | Enter DOB. | Enter SSN. | |
| Enter name. | | | Enter relationship. | | Enter DOB. | Enter SSN. | |
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| Check this box if household is eligible to receive JOBS Support Services Payments. If any JOBS Support Services payments were issued, identify those below: (checking the box, if applicable, informs the CAA what HSP services can or cannot be issued): | | | | | | | |
|  | Type of Service | | Month Received | | Amount of Service |  | |
|  | Enter service. | | Enter month | | Enter amount. |  | |
|  | Enter service. | | Enter month. | | Enter amount |  | |
|  | Enter service. | | Enter month. | | Enter amount. |  | |
| ROI on File at DHS. Please attach ROI (MSC-3010) to this referral. | | | | | | | |
|  |  | |  | |  |  | |
| **To be completed by agency receiving referral:** | | | | | | | |
| Accepted?  Yes  No | | If no, why? | | Enter reason. | | | |
| HSP Services Began (date): | | | Pick date. | | HSP Services End (date): | Pick date. | |
|  | Type of Services | | Month Received | | Amount of Services |  | |
|  | Enter service. | | Enter month. | | Enter amount. |  | |
|  | Enter service. | | Enter month. | | Enter amount. |  | |
|  | Enter service. | | Enter month. | | Enter amount. |  | |
|  | Enter service. | | Enter month. | | Enter amount. |  | |
|  | Enter service. | | Enter month. | | Enter amount. |  | |
|  | Enter service. | | Enter month. | | Enter amount. |  | |
|  | Enter service. | | Enter month. | | Enter amount. |  | |
| Signature (electronic sign) | | | | | Email | Date | |
| Enter name. | | | | | Enter email. | Pick date. | |

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| **Use the space below to include any additional notes:** |
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**INSTRUCTION FOR INTERAGENCY HSP REFERRAL FORM**

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| **Purpose** |  | This form was developed in joint cooperation with ODHS and OHCS. It is designed to refer clients for HSP services. This form does not replace verbal communication, but rather documents Interagency personal contact. This form uses an “electronic signature” by both agencies. By completing the form, the person entering their name affirms that all statements in the form are true and correct to the best of their knowledge and that statements made in the form are supported by file documentation. |
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| **Instructions** | 1. | Form may be typed or hand-written. This form does not replace personal contact. |
|  | 2. | If person referred is different than case name, add case name information. |
|  | 3. | Referring agency completes top portion of form and sends to recipient agency. |
|  | 4. | Recipient agency completes bottom portion of form and sends to referring agency. |
|  |  | **Copies of referral must be kept in client file for documenting eligibility status – no additional eligibility documentation is required if form is completed in its entirety.** |

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| **HSP Basic Eligibility** | |
| **Eligible Expenses** | HSP funds can pay for services (1) Housing related costs (rent, mortgage, moving costs, utilities, etc.); (2) Auxiliary services (transportation-related, employment-related, self-sufficiency related) (3) Case management; and (4) Data system expenses. Funds are limited to four months and a total of $8,000. |
| **Eligibility Requirements** | The program assists households that meet the program’s criteria for being literally homeless or unstably housed, have one or more qualifying child(ren), meets citizenship requirements, is either receiving TANF or has an income at or below 250% of FPL. If receiving TANF, the local ODHS agency verifies eligibility through the use of this form. No additional proof of eligibility is required. |
| **Prioritization** | Priority of HSP expansion services is given:   1. First to households applying for or receiving TANF; 2. Second to households who are TANF eligible (meeting HSP requirements). |
| **Unstably Housed Definition** | A household who:   1. Is at risk of losing their housing, and does not otherwise qualify as homeless, provided that: 2. They have been notified to vacate current residence OR otherwise demonstrate high risk of losing current housing; AND 3. Lack the resources or support networks to obtain other permanent housing. |