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| **Housing Provider Contact Information**  Agency Name:  Program Name:  HMIS Program ID:  Person Completing Form:  Email:       Phone:  Intended Case Manager (if known):  Email:       Phone: | | |  | **Number of Vacancies**    **Check Box if REPLACMENT Referral** |
| **Type of Program**  PSH  TH  RRH |  | **Household Type**  Single Adult  Family – Single-Parent Household  Family – Two-Parent Household | | |
| **Head of Household Age**  16-21  18-21  18-24  Any Age  Other: |  | **Family Size**  Any Family Size  Not Applicable (single adult/youth)        Parent(s),       Children | | |
| **Unit Size (if applicable)**  Studio/Efficiency  1BR  2BR  3BR  4BR  Other: |  | **Location**  Scattered Site  Site-Based  City:  Neighborhood:  Expected Vacancy Date: | | |
| **Homeless Status as Required by Funder**  Chronic  LTH  High Priority Homeless  HUD Homeless  MN Homeless |  | **Sobriety**  No sobriety requirement  Client must be sober  Please elaborate: | | |
| **Disability**  HoH must have disability impacting ability to work  A household member must have a disability  No disability requirement  Other: |  | **Income**  Household must have verifiable income  Minimum Monthly:        Maximum Monthly:  Household may have zero income  Maximum Monthly: | | |

**Please send completed form to:** – [CES.Hennepin@hennepin.us](mailto:CES.Hennepin@hennepin.us)