

Horizon Homes, Inc.
HCBS-CRS/BLSS Referral Form



Date: _____ Time: _____
HCBS-CRS BLSS

*Email Completed HCBS Form to:
hcbs.referral@horizonhomes.org
Email Completed BLSS Form to:
blss.referral@horizonhomes.org

Referral Source and Contact Information _____

DEMOGRAPHICS

Name: _____ D.O.B.: _____ Phone Number: _____

Address: _____

County of Residence: _____ County of Financial Responsibility: _____

Social Security #: _____ Veteran/active in the military? Yes No

Do you have any children? Yes No If yes, are your children in your custody? Yes No

Current Placement/Previous Placement: _____

Cultural Considerations: _____

COMMUNITY SUPPORTS

Case Manager(s): _____ Aware of Referral? Yes No

Legal Status: VOLUNTARY COMMITMENT: _____

Guardian: Yes No; If Yes, Name: _____

Guardian Contact Information: _____

Psychiatrist: _____ Therapist: _____ Emergency Contact: _____

Other Providers: _____

MENTAL HEALTH

Mental Illness Diagnosis: _____

Symptoms: _____

Psychiatric Hospitalizations (When/Where) _____

History of SI/attempts? Yes No When/Method _____

Current Suicidality? Yes No Plan?: _____

History of SIB: Yes No When/Type: _____

Current SIB? Yes No Type: _____

MEDICAL CONSIDERATIONS

Medical Needs/Concerns (including mobility issues, illness, and communicable disease): _____

Allergies: _____

Primary Care Provider Name and Organization: _____

Taking Meds as Directed? Yes No N/A Meds in original bottles and/or scripts? Yes No

Pharmacy Information: _____

SUBSTANCE USE

Drinking/Drug Use in the last 24 hrs/currently under the influence? Yes No. Specify: _____

History of Drinking/Drug Use? Yes No. Specify: _____

Providers Related to Substance Use: _____

In-/Outpatient SUD Treatment (When/Where) _____

NGI CNEQPEGTPU

Ngicn'kuwgul' k'ngt { 'qh'Xl'q'pegA' [gu" P q. Ur gekh{ < _____

Rtqdcv'qp'Qh'leg' "h'cr r'necdng+< _____

HPCPEKCN

K'pwtcpeg'Ego r cp{ < _____ K'pwtcpeg'K' < _____

H'pcpekcn'Y q'tngt< _____ T'gr 'Rc{ gg-aaaaaaaaaaaaaaaaaaaaaaaaaaaaa

Employment: _____

F q "{ qw'tgegk'g'qt'j' cxg'"*ej gen'dqz +< I C" UUK TUF K ECF KY ckxgt "*"J EDU'QP N[+ GRH

I, _____, give Horizon Homes Inc. permission to access my insurance information to facilitate my referral to the Horizon Homes, Inc. HCBS or BLSS program.

I, _____, give Horizon Homes, Inc. permission to contact the entities listed below my community supports/mental health sections to gather needed information to facilitate my referral to the Horizon Homes, HCBS or BLSS program.

Signature _____ Date _____

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for BLSS to: blss.referral@horizonhomes.org