Marion County
OREGON
Health & Human Services

Office Use Only					
Date Received					
Eligible	☐	Not Eligible	☐	More Info	☐
(If ineligible, provide brief explanation):					
Supervisor			Date		

Human Services Housing Referral

Referring to: ☐ **Short Term Housing Navigation** (less than 6 months, basic skills training, and housing navigation only)

☐ **Long Term Housing Navigation** (6 months or longer, case management, skills training, peer support)

Individual's (Head of Household) Name:	DOB:	Phone:
Current Address:		
Size of Household:	Age(s) of individuals in household:	
Contact preference:	If individual can't be reached, alternate contact:	
Does individual have a guardian? ☐ Yes ☐ No	If yes, name:	
If yes, relationship: ☐ Relative ☐ Court appointed ☐ Other:		Phone:
Referrer's Name:	Agency:	Phone:

1. **Is the individual, Head of Household, or child currently enrolled in any Marion County Health and Human Services Program or service** (example: WIC, ABH, I/DD Services, CBH, EASA, etc.)? ☐ Yes ☐ No
   If yes, which program or service: _____
2. **Does the individual have TANF or DHS Child Welfare involvement (*required for eligibility)?** ☐ Yes ☐ No
   If yes, please explain: _____
3. **Does the individual or Head of Household meet criteria for a **Serious and Persistent Mental Illness (SPMI)** and/or **a Substance Use Disorder (SUD) and/or Intellectual/Developmental Disability (I/DD)?**
   ☐ Yes ☐ No Diagnosis: _____
4. **Is the individual or family:** ☐ Unsheltered ☐ Homeless (ex. Couch surfing) ☐ Living in a Shelter
   ☐ At Risk of becoming unsheltered/homeless ☐ Rent burdened ☐ Other: _____
   Please explain (***Required***): _____
5. **Is the individual or Head of Household currently residing in or transitioning from licensed or supportive housing:**
   ☐ Oregon State Hospital ☐ Residential Treatment Facility/Home (RTF/RTH) ☐ Adult Foster Care (AFH)
   ☐ Supportive Housing ☐ 24 Hour-Residential ☐ Other: _____
6. **Without supported housing, would the individual or head of household be at risk of re-entering licensed residential care or the hospital?** ☐ Yes ☐ No
7. **Is the individual or family currently receiving other housing assistance (Other housing subsidy or voucher)?**
   ☐ Yes ☐ No **Is the individual or family on the waitlist for a Section 8 Housing Voucher?** ☐ Yes ☐ No
   Please explain: _____

Submit

**A mental health assessment must be completed; attach with referral if completed within the last year
*Required for DHS Housing program only

Email: HHS-Housing@co.marion.or.us Attention: Human Services Housing Fax: #503-361-2664