# Minnesota Department of Corrections
## HOUSING REFERRAL FORM

**To be completed by case manager or agent:**

**Client Information and Criteria Eligibility Review**

*Complete this box, sign, and email to DOC Housing Supports housingsupports.doc@state.mn.us*

**Client Name:** _____ **OID:**_____**Is**
**This referral is for** ☐ Rental assistance ☐ Halfway House
**Name of placement/vendor/landlord:** _____
**Is the placement/vendor landlord registered with SWIFT?** ☐ YES ☐ NO
**Supervision Agent:** _____
**Release Date:** _____

**Synopsis of current situation (Please include options explored and the results, any disabilities or disabling conditions- SUD, MH, or cognitive impairments)**

**Any children? If yes, is child support owed and how much.** _____
**List of available finances:** _____
**Total amount needed in rental assistance**_____

HALFWAY HOUSING

**Criteria Review for Halfway House funding:** *(See Adult Halfway House Placement Eligibility Guidelines 205.130E for information) (check appropriate)*

☐ Client has no alternative approved residence option and has exhausted all personal financial resources available for housing (**case note in COMS regarding what options for housing have been explored should be made**); **and**
  ☐ Client is on mandatory ISR supervision: Scores as Very High Risk on the MnSTARR 3.0 Risk Assessment tool **or**

☐ Client is supervised on a ☐ loss of life offense ☐ life sentence

*I certify that the eligibility criteria for adult halfway house placement have been reviewed and this client meets the eligibility criteria. Based upon the foregoing, the case manager requests approval for funding the placement.*
**Case Manager Name:** _____**Phone:**_____ **Date:**_____
**DOC Facility (case manager's worksite):** _____

***If client meets above criteria, case manager contacts halfway house representative:***

**Halfway House Placement Confirmation**

*Complete this box, sign, and transmit to grants and subsidies if housing available*

**I spoke with the representative of:**
☐ 180 Degrees ☐ Damascus Way ☐ Duluth Bethel ☐ RS Eden

**The representative determined that a room is:**
☐ Available, anticipated bed availability date is: _____for the above- named client based upon DOC funding for up to 60 days.
☐ Not Available Retain form in base file.

**Print Name of Representative:** _____ **Date:**_____

**To be completed by Housing Supports:**

**DOC Housing Funding Approval**

*Complete this box, sign, and transmit to appropriate case manager*

Funding: ☐ Approved ☐ Not Approved

Authorized Staff Signature: _____