Community Intervention Housing Referral

Department of Health and Human Services • Milwaukee County Special Needs Housing Division

Filling out this form in its entirety is required for all referrals. Forms are to be emailed to Emily.Franklin@milwaukeecountywi.gov

Date: _____

Consumer Name: _____ D.O.B. _____ Sex: M ☐ F ☐

CIH Admission request date: _____

Does the consumer have case management? Yes ☐ No ☐ Case manager referral pending: Yes ☐ No ☐

Case manager's name: _____ Agency: _____

Level of Care: CSP ☐ TCM ☐ CCS ☐ Other ☐ _____

Telephone #: _____ Case manager's email: _____

Type of referral:

BHD ☐ CRC-North ☐ CRC-South ☐ Crisis Stabilization ☐ Other ☐ _____

Name of person making referral: _____ Agency: _____

Description for referral and exit plan (describe in brief):

_____

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TO BE COMPLETED BY THE COMMUNITY INTERVENTION SPECIALIST:

Date of CIS assessment: _____ **Referral for CIH: Approved** ☐ **Denied** ☐

CIH Location: _____ **Provider/telephone#:**_____

Community Intervention Specialist: _____ **Date:** _____