



Host Home Program Referral Application

Thank you for your interest in Lutheran Services in Iowa's Host Home Program. Please complete this form, and send the following documents for our team to review:

☐ Current Social History ☐ Current Plan ☐ Most Recent Assessment (SIS/LOCUS/Mayo-Portland)

☐ Current Medication List Date of Referral: _____

Legal Name: _____ Preferred Name (if applicable): _____

Date of Birth: _____ Gender: _____ Gender Identity/Pronouns: _____

Current Address: _____

Primary Diagnosis: _____

Funding Source: ☐ Amerigroup ☐ Iowa Total Care ☐ IME/HIPP ☐ Molina ☐ County _____

☐ Other: _____

MCO: ☐ Amerigroup ☐ Iowa Total Care ☐ Molina Medicaid ID: _____

MCO ID: _____

Service Type: ☐ Habilitation ☐ Intellectual Disability ☐ Brain Injury ☐ Other: _____

For Habilitation and Intellectual Disability Services, please complete the following section:

Intellectual Disability: ☐ H2016 funding ☐ S5136 funding

Current Tier Level: ☐ U1 ☐ U2 ☐ U3 ☐ U4 ☐ U5 ☐ U6

Habilitation Services (UD or higher level of care required) : ☐ UD ☐ U8 ☐ U9

Have there been any changes to the individual's tier level in the past 6 months? : ☐ yes ☐ no

If yes, please indicate tier changes and dates: _____

Case Manager/Care Coordinator: _____ Organization: _____

Phone: _____ Email: _____

Does the individual have a legal guardian? ☐ yes name: _____ ☐ no

Does the individual currently work, or receive SSI/SSDI? ☐ yes ☐ no (monthly amount): _____

What area(s) of the state is this individual interested in receiving services?

☐ Statewide ☐ Eastern ☐ Northwest ☐ Central ☐ Southwest ☐ Southeast ☐ Other

Please provide specific counties/towns/areas:

What services is the individual currently receiving, or has received in the past 6 months?

Has the individual been given a notice by a current provider, or been discharged from services in the past 6 months?

Would this individual be comfortable in a host home where children were present?

Please answer the questions below. For any questions answered yes, please provide additional information in the provided spaces.

Does this individual have any mobility or accessibility special equipment or needs? ☐ yes ☐ no

Does the individual have any specialized medical needs? ☐ yes ☐ no

Does this individual have a current court committal for services? ☐ yes ☐ no

Does this individual have any criminal history, or history of arrests/incarceration? ☐ yes ☐ no

Does the individual have any pending charges? ☐ yes ☐ no

Is the individual currently on probation or the sex offender registry? ☐ yes ☐ no

Does the individual have a history of aggression, property destruction, or assault? ☐ yes ☐ no

Does the individual currently, or have a history of, substance abuse? ☐ yes ☐ no

Does the individual currently use alcohol or nicotine/tobacco products? ☐ yes ☐ no

Does the individual have a history of self harm or suicidal ideation? ☐ yes ☐ no

Please use the space below to provide any additional information for this individual that would be important for us to know.

The information we have asked you to provide is necessary for the effective administration of the services for which you are applying. The information collected will only be used by authorized agency personnel. A referral application does not guarantee placement. If you have any additional questions, please contact us at hothome@LSIowa.org.