



Lutheran Services in Iowa
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/interRAI/Mayo-Portland).

Date of Referral: _____

Full Name: _____ Gender: _____ Date of Birth: _____

Current Address: _____

Primary Diagnosis: _____

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

MCO: ☐ Amerigroup ☐ Iowa Total Care 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: (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

Has 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 areas 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? ☐ yes ☐ no

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

Would this individual be comfortable in a host home where children were present? ☐ yes ☐ no

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. Referral application does not guarantee placement.