South Dakota Department of Social Services
Strong Families - South Dakota's Foundation and Our Future

homeagainSD

REFERRAL

Please complete this form and send to HomeAgain@state.sd.us

With this referral form, you can help put yourself or someone you know back on the path to home. Don't hesitate to contact us if you have any questions about the referral process.

Client Information:

First Name: _____ **Last Name:** _____

DOB: ____/____/_____ **Age:** ____ **Phone Number:** _____

Medicaid ID #: _____

Medicaid recipient: ☐ Yes ☐ No ☐ Application pending

Address of current residence: _____

City, State, Zip code: _____

What type of residence is this?:

☐ Nursing home (LTC) ☐ Assisted living facility ☐ Hospital
☐ Home ☐ Apartment ☐ SDDC

How long has the individual lived at his or her current residence?: _____

Address (or town) the individual would like to live: _____

When would the individual would like to move?: _____

What type of housing would the individual want to live in?:

☐ Home ☐ Apartment ☐ Group home (4 or less) ☐ Assisted living facility

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Contact Information

Referred by (First and last name): _____

Phone number: _____ **Email:** _____

Guardian (if applicable): _____

Guardian number: _____ **Guardian Email:** _____

Relationship: _____

Support Information

What service(s) are needed?: _____

- ☐ Housing (security deposit, temporary rent, home set up)
- ☐ Transportation
- ☐ Assistive Technology Devices (ramp, lift, grab bars, etc.)
- ☐ Other: _____

Additional Information: