

MARYLAND RECOVERYNET  
INITIAL HOUSING REQUEST FORM

*Note: This form is to be used by the MDRN care coordinator to submit requests for recovery housing services. An incomplete request will not be processed and will be denied. Please send this request [mdrn.housinginfo@maryland.gov](mailto:mdrn.housinginfo@maryland.gov).*

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**CLIENT INFORMATION**

**M# (if available)** \_\_\_\_\_

Client's Last Name: \_\_\_\_\_ Client's First Name: \_\_\_\_\_

SS# \_\_\_\_-\_\_\_\_-\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: Male Female Transgender

Client's Address and Program Name, if applicable:

\_\_\_\_\_

Email Address: \_\_\_\_\_ Phone Number: \_\_\_\_-\_\_\_\_-\_\_\_\_

**REFERRAL SOURCE INFORMATION:**

County: \_\_\_\_\_

State Care Coordination Agency's Name: \_\_\_\_\_

Name and Title of person submitting request: \_\_\_\_\_

Service Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

Direct Number: \_\_\_\_-\_\_\_\_-\_\_\_\_ Fax Number: \_\_\_\_-\_\_\_\_-\_\_\_\_

**HOUSING REFERRAL INFORMATION (Note: all recovery housing requests must be made to a MCORR certified recovery residence).**

**Requested Authorization Start Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Recovery Residence Name: \_\_\_\_\_

Service Address: \_\_\_\_\_

Contact Person, Title: \_\_\_\_\_

Contact Number: \_\_\_\_\_

**ELIGIBILITY:**

1. Has eligibility been verified for this individual? Yes No

Explain: \_\_\_\_\_

2. Is this individual at risk of homelessness? Yes No

Explain: \_\_\_\_\_

3. Did this client reside at this service location prior submitting this initial housing request?

Yes No

4. If yes, please list the move-in date: \_\_\_\_/\_\_\_\_/\_\_\_\_

5. If no, please list the anticipated move-in date: \_\_\_\_/\_\_\_\_/\_\_\_\_

6. If requesting housing, what is the service recipients' plan for housing after 60 days?

Explain: \_\_\_\_\_