Moving Home Program Referral

Head of Household Name		Desired Community
☐ Yes ☐ No	An adult in this household is subject to a registration requirement on a state sex offender list.	

Service Provider Contact Information (Questions? Go to State of Alaska DHSS Moving Home Program)

Name	
Agency Name	
Mailing Address	
Telephone	E-Mail

Fax or e-mail the entire package to: Beth Wilson, Beth.Wilson@alaska.gov, fax: (907) 269-3786.

For State of Alaska Department of Health and Social Services Use Only

1. Attached to this referral is an AHFC application and Family Member Details (if applicable).
2. This person/family is: ☐ Homeless ☐ At Risk of Homelessness

☐ Moving Home Program (MTW Funds)	☐ Moving Home Program (SAMHSA Funds)
I certify that this household is eligible for community-based, long-term services as provided through Medicaid waivers, Medicaid state plan options, state funded services, or other appropriate services related to the target population, **and** • Meets the U.S. Department of Housing and Urban Development's definition of a disabled family (24 CFR 5.403), **or** • Is an Alaska Mental Health Trust Authority beneficiary	I certify that this household meets the definition of a behavioral health diagnosis as specified under the SAMHSA grant

DHSS Selection Committee Signature ____________________ Date ____________

Fax or e-mail the entire package to Regina O'Keefe, Email: rokeefe@ahfc.us, Fax: (907) 338-1683.

For AHFC Use Only

Date Received ____________ To ____________

Date Emailed ____________ Signature ____________