Reset Email

REFERRAL FOR SERVICES

7900 Excelsior Blvd., Ste 200 • Hopkins, MN 55343
Phone: 952.658.8995 • Fax: 952.777.2263

Intake Date: _____

Client Information

Client Name: _____ DOB: _____
Street Address: _____ Phone: _____
City: _____ Language: _____
State: _____ Zip Code: _____ Gender: ☐ M ☐ F ☐ Other

Health Information

Dx: _____

Insurance Information

PMI #: _____ Insurance: _____
Waiver: ☐ EW ☐ CADI ☐ CAC ☐ AC ☐ DD ☐ BI ☐ None Insurance ID: _____

Services Requested

In-Home Services

Type of Service	Hours per day/week	Comments/Description
☐ PCA	_____ day	
☐ HMK	_____ week	
☐ ICLS	_____ week	
☐ IHS Services:	_____ week	
☐ w/training ☐ w/o training ☐ w/family training		
☐ Respite	_____ week	
☐ Night Supervision	_____ week	
☐ Chore Services (please specify)	_____ week	
☐ Housing Stabilization	_____ week	
☐ consultation ☐ transition ☐ sustaining		
☐ Other services	_____ week	

Transportation	Comments/Description
☐ Medical Transportation	
☐ Community Transportation	

Social Services	Comments/Description
☐ MNsure Assistance	
☐ Assistance with Applications	

Case Manager/Care Coordinator Information

CM/CC Name: _____ Phone: _____
CM/CC Email: _____ Fax: _____
How did you hear about us? _____

Additional Information

Caregiver Gender Preference? ☐ Yes ☐ No If yes, please check: ☐ M ☐ F
Client lives alone? ☐ Yes ☐ No If no, please list: _____
Pets in the Household? ☐ Yes ☐ No If yes, please list: _____
Current smoker? ☐ Yes ☐ No Does anyone else in the household smoke? ☐ Yes ☐ No
Hx of SPMI? ☐ Yes ☐ No Hx of violence? ☐ Yes ☐ No Guns at Home? ☐ Yes ☐ No
Is client a registered sex offender? ☐ Yes ☐ No Free Parking? ☐ Yes ☐ No

Comments/Notes