|  |  |  |
| --- | --- | --- |
| referral form | |  |
|  |

**Person Information**

|  |  |  |
| --- | --- | --- |
| First Name: | Last Name: | |
| Date of Birth: Gender: ❑ Male ❑ Female | Race: | Social security Number: |
| Address: | City: | State: MN  Zip: |
| Phone Number: | Cell Number: | Work Number: |

**Reason(s) for Referral (please check box**): ❑ ARMHS ❑ 24 hr. Emergency Services ❑ Homemaker ❑ Pycho-therapy ❑ In-Home Family Support ❑ Housing Access Coordination ❑ Behavioral Support ❑ Specialist Services ❑ Chore Serv. ❑ ILS

❑ Supported Living Services Adults ❑ Supported Employment Services ❑ Transportation

❑ Other specify:

Diagnosis (mental health and physical health):

**SPECIAL NEEDS:**

Is there any known cultural consideration needs? ❑ Yes ❑ No specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any gender preference regarding the assigned staff? ❑ Yes ❑ No Is yes? ❑ Male ❑ Female ❑No preference

**Insurance Information** - Primary insurance: ***(please check)***

|  |  |
| --- | --- |
| ❑ **UCARE** ❑ MEDICA❑ Health Partners ❑ Blue Cross Blue Shield ❑ Straight MA ❑ Metropolitan Health Plan ❑ Other: | PMI Number: Medical Assistance Number: |
| Primary Ins. #  Group# | Other insurance information: |

**Legal status**

|  |
| --- |
| □ responsible for self □ under guardianship □ under commitment |

**Legal representative contact information**

|  |  |  |
| --- | --- | --- |
| First name | Last name | |
| Address: | City: | State: MN Zip: |
| Best Contact Number: | Fax Number: | Email: |

**Primary emergency contact information**

|  |  |
| --- | --- |
| First name | Last name: |
| Best Contact Number: | Relationship: |

Does this person have ***(mark if known; leave blank if unknown):***

Mental Health Case Manager?  Yes  No

Waiver Case Manager?  Yes  No, - Type:  Brain Injury  CAC  CADI  DD  EW

Care Coordinator with primary clinic or insurance company?  Yes  No

Other: If other, please specify type of provider: ***(such as physician, therapist, psychiatrist, child protection wkr. etc.)***

Provider Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please enter provider information below

**Case Manager/ Other provider type contact information/ Referral Source** ❑ N/A ❑ Self

|  |  |  |
| --- | --- | --- |
| First Name | Last Name: | |
| Address: City: Zip:  MN | | |
| Office number: | Office Fax: | Cell number: |
| Agency Name: | Would you like to be updated on all assessment scheduling & treatment of services? ❑ Yes ❑ No | |

***At time of referral, you may submit any other supporting documents (if you have them available):***

*\*Most current Diagnostic Assessment \*Copy of Functional Assessment / LOCUS \* County Case Plan \*Crisis Plan*

***Referrals and copies of documents can be mailed or faxed to:***

***METRO CARE HUMAN SERVICES***

***6043 HUDSON ROAD SUITE 399J***

***WOODBURY MN 55125***