referral form- ReCuperative Care

**Personal Information**

|  |  |  |
| --- | --- | --- |
| First Name:  | M.I.: | Last Name: |
| Date of Birth: | Gender: [ ]  Male [ ]  Female[ ]  Prefer not to answer[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Race:  | SSN: |
| Address: | City:  | Zip code:  |
| Phone Number: | Cell Number:  | E-mail address: |

**Reason(s) for Referral**

|  |
| --- |
| [ ]  Recuperative Care \*[ ]  Positive Support Services (PSS)[ ]  Integrated Community Supports (ICS) [ ]  Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Diagnosis** (mental health and physical health) **(please include diagnostic code as well as description)**

|  |
| --- |
|  |

**Special Needs**

|  |
| --- |
| Are there any known cultural consideration needs? [ ]  Yes [ ]  No specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Is there any gender preference regarding the assigned staff? [ ]  Yes [ ]  No If yes: [ ]  Male [ ]  Female [ ] No preferenceAllergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other (be specific): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Insurance Information**

|  |  |
| --- | --- |
| Primary insurance: ***(please check box)***[ ]  **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:  |

\*Recuperative Care is a 60 day short-term stay.

Have a MN Choices Assessment scheduled ? Yes/No. If Yes, when\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have applied for SMRT or SSDI/SSI? If Yes, which one and when\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How soon is housing needed?

[ ]  > 3 months [ ] < 3 months [ ]  < 6 months [ ]  < 1 year

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

Mental Health Case Manager? [ ]  Yes [ ]  No **(If yes, enter information below)**

Waiver Case Manager? [ ]  Yes [ ]  No **(If yes, enter information below)**

Waiver Type: [ ]  Brain Injury [ ]  CAC [ ]  CADI [ ]  DD [ ]  EW

Care Coordinator with primary clinic or insurance company? [ ]  Yes [ ]  No **(If yes, enter information below)**

Other: (***Please specify type of provider such as physician, therapist, psychiatrist, child protection worker, etc.)***

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

**Mental Health Case Manager Information**

|  |  |
| --- | --- |
| First Name: | Last Name:  |
| Address: City: Zip code:   |
| E-mail Address: |
| Office number: | Office Fax: | Office number: |
| Agency Name:  | Would you like to be updated on all assessment scheduling & treatment of services? [ ]  Yes [ ]  No |

**Waiver Case Manager Information**

|  |  |
| --- | --- |
| First Name: | Last Name:  |
| Address: City: Zip code:   |
| E-mail Address: |
| Office number: | Office Fax: | Office number: |
| Agency Name:  | Would you like to be updated on all assessment scheduling & treatment of services? [ ]  Yes [ ]  No |

**Care Coordinator Information**

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

**Legal Status & Legal Representative Contact Information**

|  |
| --- |
| [ ]  responsible for self [ ]  under guardianship **(complete section below)** [ ]  under commitment  |
| First name: | Last name: |
| Address: | City:  | Zip code: |
| Best Contact Number:  | Fax Number:  | Email: |

**Primary Emergency Contact Information**

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

**Case Manager/ Other Provider Type Contact Information/ Referral Source**

|  |  |
| --- | --- |
| First Name: | Last Name:  |
| Address: City: Zip code:   |
| E-mail Address: |
| Office number: | Office Fax: | Office 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 \*CSSP \*IAPP \*SMA*

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

**METRO CARE HUMAN SERVICES**

**2056 Woodlane Drive**

**Woodbury, MN 55125**

**Fax: (651) 528-7897 Attn: Arnold Kubei**

**E-mail:** **info.intake@metrocareservicesmn.com** **Subject: Referral Form**