LIVE WELL MINNESOTA
Service Referral Form

Welcome to Live Well Minnesota! We offer multiple services so if the service you're looking is not listed, please contact us via email or call us.

Please note, this is a preliminary data gathering to quickly determine if a referral meets criteria and establish a referral for the correct service.

Direct Contact: 612-460-5094/612-800-4088 (Isaak, Ceo/Manager)

Send docs to: *info@livewellmn.org*

Fax: *952-303-5273*

Office: *952-303-5273*

Date Referral Form Submitted:	Service Requested Start Date:
Referring Agency Type:	Referral Agency Contact:
Person referred by:	Relationship to Person:

Reason for the referral:

SERVICE INQUIRY DESCRIPTION

Type of Service Request:

- ☐ PCA Services — Daily Hours…… (Weekly total) _____
- ☐ ARMHS Services — Daily Hours…… (Weekly total) _____
- ☐ HSS (Housing Stabilization) — Daily Hours…… (Weekly total)_____
- ☐ Social Security Advocacy Services — (Service Type:……)

Waiver Services (HCBS

- ☐ Type Service Here — Daily Hours…… (Weekly total) _____

Any Spend Down/Copay?

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CLIENT DEMOGRAPHIC	
Name:	Date of birth:
Address:	Email address:
Cell phone number:	Language(s) spoken:
Guardianship type (self, private, public):	Gender
Marital status:	Does the Client have own worker/PCA? (Yes) (No)
Household Info: Any pets? (Yes) (No)	Does the client smoke? (Yes) (No)
FINANCIAL INFORMATION	
Social Security Number (SSN):	Medical Assistance Number:
County of responsibility:	PMI number:
County of financial responsibility:	Waiver Type: Please type:…….. (We do take all waivers)!
MEDICAL INFORMATION	
Diagnoses:	
Allergies:	
Protocols (seizure, diabetic, etc.):	
Medical equipment, devices, or adaptive aides or technology used:	Specialized dietary needs:

GENERAL CONTACT INFORMATION	
Name	**Address and telephone numbers**
Legal representative:	
Authorized representative:	
Primary emergency contact:	
Case manager:	
CADI Case Manager:	
Financial worker:	
Residential contact:	
Vocational contact:	
Other service provider:	

HEALTH-RELATED CONTACT INFORMATION	
Name	**Address and telephone numbers**
Primary health care professional:	
Psychiatrist:	
Other mental health professional:	
Neurologist:	

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Dentist:	
Optometrist/Ophthalmologist:	
Audiologist:	
Pharmacy:	
Hospital of preference:	
Other health professional:	
Other health professional:	

Please provide supporting documents

- ☐ CSSP/ISP/CSP
- ☐ Evaluation/Assessment
- ☐ Other_____

Important Info We Should Know: