|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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?  |
| 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:  |  |
| 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: |