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