referral form

**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**

|  |
| --- |
| Basic Support Services Housing Access Coordination (HAC)  Intensive Support Services  24-hr. Emergency Assistance ~ Tier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Independent Living Services ~ ILS Hours per Week: \_\_\_\_\_\_\_\_\_\_\_\_\_  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 preference  Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  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: |

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 e-mailed to:***

***HelpingAngelsHomeCare@gmail.com***

***Contact@helpingangelshomecare.com***

***Subject: Referral***

***Call:*** (612) 259-8570