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 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:  |

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