

INTEGRATED COMMUNITY SUPPORTS REFERRAL FORM

Referral Date: _____

Personal Information

First Name:		M.I.:	Last Name:		PMI No:
Date of Birth:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Other: _____		Race:		SSN:
Address:			City:	Zip code:	
Phone Number:		Cell Number:		E-mail address:	
Diagnosis Codes					

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 ? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Primary Emergency Contact Information

First name:		Last name :	
Best Contact Number:		Relationship:	

Special Needs

Are there any known cultural consideration needs? <input type="checkbox"/> Yes <input type="checkbox"/> No specify: _____	
Allergies: _____	
Other (be specific): _____	

Level of Need

Does this person have a criminal background? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you aware of any drug/ alcohol use? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does this person use the following? (mark all that apply) <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> Wheelchair	
<input type="checkbox"/> Other: _____	
Does this person have an income source? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, enter information below)	
Type of income: _____	Amount: \$ _____
Type of income: _____	Amount: \$ _____
Type of income: _____	Amount: \$ _____
Type of income: _____	Amount: \$ _____
Does this person currently have a lease? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, when will it end? _____	
How soon does this person want/need to move? (exact date not necessary) _____	
Other important notes (please be specific):	

Care Preferences

Will this person need Transitional Services? (choose all that apply)
<input type="checkbox"/> Deposit <input type="checkbox"/> Movers <input type="checkbox"/> Household items <input type="checkbox"/> Furniture

Legal Status & Legal Representative Contact Information

<input type="checkbox"/> responsible for self			<input type="checkbox"/> under guardianship (complete section below)			<input type="checkbox"/> under commitment		
First name:			Last name:					
Address:			City:			Zip code:		
Best Contact Number:			Fax Number:			Email:		

****At time of referral, we ask that you submit the individuals Face Sheet, CSSP, MNChoice and any other supporting documents (if you have them available) for review**

Case Manager Signature: _____ Date: _____

Submit