FAMILY INNOVATIONS, INC.

FAX # FOR HOME BASED REFERRALS: 651-925-0212

Community-Based Services Intake Referral – Adults (ARMHS)

Client Information

Client Name: _____ Age: _____ DOB: __/__/____ Gender: M ☐ F ☐

Soc. Sec. #: ____ - ___ - _____ Race(s): _____

Address: _____ City: _____ ST: ____ Zip: _____

Home Phone: _____ Work/Cell Phone: _____

Number of adults living in the home: _____ Number of children living in the home: _____

Legal Guardian Information (if adult has a designated guardian)

Legal Guardian's name: _____ Phone: _____

Address: _____ City: _____ ST: _____ Zip: _____

Referral Information

Referral Source: _____ Agency/Division: _____

Phone: ( ) _____ (w/c) Fax: ( ) _____

Current Soc. Serv./Psych. Involvement: Yes ☐ No ☐ If yes, please describe: _____

Current Diagnoses (if any): 1. _____ 2. _____

Current Concerns: _____

_____

Medications: _____

Reason for Referral: _____

_____

_____

Urgent: yes ☐ **no** ☐ If yes, please describe: _____

Therapist Requested: _____

Financially Responsible Party (*please check all that apply*):

☐ Medical Assistance

MA #: _____

☐ PMAP: _____

ID #: _____

Group #: _____

☐ County: _____

please include ppwk/cty contract with referral form

☐ 3rd Party Insurance

Carrier: _____

Policy Holder: _____

Policy #: _____

Group #: _____

Prov. Serv. #: ( ) _____ - _____

Please fax completed referral form, along with ALL of the following (that apply) to (651) 925-0212:

☐ **Current Diag. Assess.** ☐ **Referring Agency Release** ☐ **Referral Source Release** ☐ **County Contract/Ppwk**