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

Home-Based Services Intake Referral

Client Information

Client Name: ____ Age: _____ DOB: __/__/____ Gender: M ☐ F ☐
Soc. Sec. #: ____ - ___ - _____ Race(s): ____
Address: __________________________________ City: _____________________________ ST: ____ Zip: __________
Primary Caretaker: __________________________________ Relationship: _______________________________________
Ph#1: ( ) ______________ (h/w/c) Ph#2: ( ) ______________ (h/w/c) Ph#3: ( ) ______________ (h/w/c)
Family members/others living in the home (*please specify whether adult or child*): ____________________________ (a/c)
______________________________ (a/c) ______________________________ (a/c) ____________________________(a/c)
______________________________ (a/c) ______________________________ (a/c) ____________________________(a/c)

Parent/Caretaker Information

Please list Parent or Caretaker names, addresses, and phone numbers, if different from above:

Parent Name: ______________________________________ Parent Name: ______________________________________
Address: ____ Address: ____
City: _________________________ ST: ____ Zip: _______ City: _______________________ ST: ____ Zip: ________
Phone: ( ) ________________ (h/w/c) Phone: ( ) _______________ (h/w/c)
***Legal Guardian (if not parent): ______________________________________ Phone: ( ) _______________ (h/w/c)**

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. #: ( ) _____ - _________

Referral Information

Referral Source: ______________________________________ Agency/Division: ___________________________________
Phone: ( ) ________________ (h/w/c) Fax: ( ) ________________
Current Soc. Serv./Psych. Involvement: Yes ☐ No ☐ If yes, please describe: _________________________________
Current Diagnoses (if any): 1. ____________________________________ 2. ____________________________________
Current Concerns: ____
Urgent: yes ☐ **no** ☐ If yes, please describe: ____

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**