

**DO NOT BACK FILE****REFERRAL FORM****RETAIN IN  
PERMANENT FILE**

Applicant's Name				Date	
Current Address	<i>Street</i>		<i>City</i>	<i>State</i>	<i>Zip</i>
Phone		Social Security		Birth Date	
M.A.#			Medicare #		
Medicare Part D			Other Insurance		
Primary Diagnosis					
Other Diagnoses					
Reason for Referral					
Cultural Considerations					
Marital Status			Citizenship Status		
Language spoken or understood					
Legal Representative	<i>Name</i>			<i>Phone</i>	
Address			Email		
County of Financial Responsibility					
Case Worker			Phone		
Address			Email		
Case Management Responsibility					
Case Worker			Phone		
Address			Email		
Funding Source					

**Attach the following referral information if applicable:**

- Medical Information including Nursing Evaluation, complete Medication List and Care Plan
- Copy of latest Health and Physical Exam
- Support Plan and/or Support Plan-Addendum including assessments
- Behavioral information including Positive Behavioral Support Plan
- Recent Hospitalization and Discharge Information
- Any previous PCS services
- Most recent diagnostic assessment
- Legal issues – pending legal issues, past legal issues, court orders, etc.
- Type of service requesting
- Most recent education and/or vocational report, if applicable
- MNChoices Assessment
- Any additional information