METRO CARE HUMAN SERVICES REFERRAL FORM

Referral Date: _____

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

☐ Respite Care (out of home) ☐ Housing Stabilization Services
☐ Positive Support Services (PSS) ☐ Pre- Vocational Services
☐ Relocation Services (RSC) ☐ Specialist Services
☐ ICS Services ☐ Chores Services
☐ 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 preference

Allergies: _____

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 mailed, faxed, or e-mailed to:

METRO CARE HUMAN SERVICES
2056 Woodlane Drive,
Woodbury, MN 55125
Fax: (651) 528-7897
E-mail: info.intake@metrocareservicesmn.com Subject: Referral Form