MAXIMAL CARE REFERRAL FORM

Personal Information

First Name:	M.I.:	Last Name:	
Date of Birth:	Gender: ☐ Male ☐ Female ☐ Prefer not to answer ☐ Other:_____	Race:	SSN:
Address:		City:	State: MN Zip:
Phone Number:		Cell Number:	Email Address:

Reason(s) for Referral

- ☐ Moving Home Minnesota (MHM)
- ☐ MHM Comprehensive Community Support Services
- ☐ Relocation Services (RSC)
- ☐ Personal Support
- ☐ Housing Stabilization Services (HSS)
- ☐ Night Supervision
- ☐ Independent Living Services - ILS Hours per Week: _____

Diagnosis (mental health and physical health) **(please include diagnostic code as well as description)**

Special Needs

Are there any consideration needs? ☐ Yes ☐ No if yes, specify: _____

Is there any gender preference regarding the assigned staff? ☐ Yes ☐ No If yes: ☐ Male ☐ Female ☐No preference

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: State: **MN** Zip:	
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	

Waiver Case Manager Information

First Name:	Last Name:	
Address:	City: State: **MN** Zip:	
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	

Care Coordinator Information

First Name:	Last Name:	
Address:	City: State: **MN** Zip:	
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

☐ responsible for self	☐ under guardianship **(complete box below)**	☐ under commitment

Legal Representative Contact Information

First name:	Last name:	
Address:	City:	State: **MN** Zip:
Best Contact Number:	Fax Number:	Email:

Primary Emergency Contact Information

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

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 *CSSP*

Referrals and copies of documents can be mailed, faxed, or e-mailed to:

Maximal Care LLC
1533 University Ave. W. SUITE 106
Saint Paul, MN 55104
Fax: (888)6891828
E-mail: tina@maximalcare.com Subject: Referral Form