

FALADCARE LLC REFERRAL FORM

Personal Information

First Name:		M.I.:	Last Name:	
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Other: _____	Race:	SSN:	
Address:		City:	State: MN Zip:	
Phone Number:		Cell Number:	Work Number:	

Reason(s) for Referral

<input type="checkbox"/> Counseling Services	<input type="checkbox"/> Housing Access Coordination (HAC)
<input type="checkbox"/> Relocation Services (RSC)	<input type="checkbox"/> Waiver Transportation
<input type="checkbox"/> 24-hr. Emergency Assistance - Tier: _____	
<input type="checkbox"/> Independent Living Services - ILS Hours per Week: _____	
<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No specify: _____
Is there any gender preference regarding the assigned staff? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> No preference
Allergies: _____
Other (be specific): _____

Insurance Information

Primary insurance: <i>(please check box)</i> <input type="checkbox"/> UCARE <input type="checkbox"/> MEDICA <input type="checkbox"/> Health Partners <input type="checkbox"/> Blue Cross Blue Shield <input type="checkbox"/> Straight MA <input type="checkbox"/> Metropolitan Health Plan <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Legal Status

<input type="checkbox"/> responsible for self	<input type="checkbox"/> under guardianship (complete box below)	<input type="checkbox"/> under commitment
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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:		

Case Manager/Other Provider Type Contact Information/Referral Source

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? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Referrals and copies of documents can be mailed, faxed, or e-mailed to:
FALADCARE LLC
6043 HUDSON ROAD, SUITE 399j
WOODBURY, MN 55125
Fax: (651) 231-0704 Attn: ERNISHA ROBERTS
E-mail: Cfaladus@gmail.com Subject: Referral Form