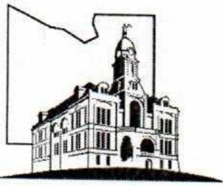

BLUE EARTH
COUNTY

MnCHOICES Assessment Referral Form

<table>
<tr><td>Date:</td><td colspan="2">Referral Source Name:</td></tr>
<tr><td>Phone:</td><td colspan="2">Referral Source Relationship to the Individual:</td></tr>
<tr><td colspan="3">Client Information:</td></tr>
<tr><td>Name:</td><td colspan="2">Date of Birth:</td></tr>
<tr><td>Social Security Number:</td><td colspan="2">PMI:</td></tr>
<tr><td colspan="3">Marital Status: ☐ Single/Never Married ☐ Married ☐ Widowed ☐ Divorced ☐ Unknown</td></tr>
<tr><td colspan="3">Address:</td></tr>
<tr><td>City:</td><td>State:</td><td>ZIP:</td></tr>
<tr><td>Phone Number:</td><td colspan="2">County of Financial Responsibility:</td></tr>
<tr><td>Email Address:</td><td colspan="2">Preference to be contacted:</td></tr>
<tr><td>Language Spoken:</td><td colspan="2">Interpreter Needed ☐ Yes ☐ No</td></tr>
<tr><td>Certified Disabled: ☐ Yes ☐ No If yes ☐ Social Security or ☐ State Medical Review Team (SMRT)</td><td colspan="2">Sex: ☐ Male ☐ Female</td></tr>
<tr><td colspan="3">Waiver Program Interested In: ☐ AC ☐ EW ☐ CADI ☐ CAC ☐ BI ☐ DD ☐ PCA ☐ CSP Only</td></tr>
<tr><td colspan="3">Services Interested in:</td></tr>
<tr><td colspan="3">Services currently receiving and notes:</td></tr>
<tr><td colspan="3">Current Living Situation
☐ With others, if with others: ☐ Spouse ☐ Parents ☐ Young Children ☐ Adult Children
☐ Alone ☐ Assisted Living ☐ Nursing Facility ☐ Other</td></tr>
</table>

Legal Authority

Does the person have someone who signs documents or helps make decisions about health care, money or other issues?

☐ No ☐ Yes, if yes

☐ informal decision-making support ☐ Responsible Party ☐ Power of Attorney (POA) ☐ Guardian

☐ Parent. If minor child, need parent's name: Date of Birth:

☐ Other:

Name:		Relationship to Individual:
Address:		
City:	State:	ZIP
Phone:		Email:

Emergency Contact

Name:		Relationship to Individual:
Address:		
City:	State:	ZIP
Phone:		Email:

Contact for Scheduling

Name:		Relationship to Individual:
Address:		
City:	State:	ZIP
Phone:		Email:

Insurance and Financial Status

Insurance

Medical Assistance

☐ On Medical Assistance ☐ Needs to apply for Medical Assistance

☐ Has application and needs to complete and return ☐ Has applied for Medical Assistance, result pending.

Private Insurance:	Policy Number:	Effective Date:
Medicare A, B, D	Policy Number:	Effective Date:

Veteran Status ☐ Yes ☐ No ☐ Unknown Veteran's Benefits ☐ Yes ☐ No ☐ Unknown

Financial Status

If Married

☐ Liquid assets less than or equal to $50,000 ☐ Liquid assets greater than $50,000 ☐ Unknown

If Single

☐ Liquid assets less than or equal to $25,000 ☐ Liquid assets greater than $25,000 ☐ Unknown

Providers	
Primary Physician Name:	Phone Number:
Mental Health Provide:	Phone Number:
Home Care Agency:	Phone Number:
Specialty Clinic:	Phone Number:
Other Provider:	Phone Number:

Diagnosis	
1.	2.
3.	4.

Assistance needed in the following areas:

- ☐ Sitting up/moving around in bed
- ☐ Getting in/out of bed/chair
- ☐ Grooming (combing hair, brushing teeth, shaving)
- ☐ Toileting: any incontinence? ☐ Yes ☐ No
- ☐ Dressing
- ☐ Other:
- ☐ Other:
- ☐ Walking
- ☐ Bathing
- ☐ Eating
- ☐ Tube Feedings
- ☐ Injections
- ☐ Wound Care
- ☐ Oxygen Therapy
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ IV Therapy
- Medication Compliance

Referral Reason
Caregiver need ☐ Supports requested ☐ Permanent loss ☐ Inability of caregiver/Temporary loss Comment:
Safety Concern: ☐ Falls ☐ Supervision ☐ Harmful behaviors Comment:
Behavioral or Emotional Concerns: ☐ Yes ☐ No Comments:
Concerns regarding a child's communication, learning, or social skills: ☐ Yes ☐ No Comments:
Memory Concerns: ☐ Yes ☐ No Comments:
Housing/Living arrangements concerns: ☐
Services and Supports: ☐ Current services not adequate ☐ Education/school/transition ☐ Modifications ☐ Specialized equipment and supplies Comments:
Other Concerns: