



Anoka County

HUMAN SERVICES DIVISION

Community Social Services and Behavioral Health

MnCHOICES Assessment Referral Form

Please complete referral form, save, and send as an attachment to Long Term Services and Supports Intake at: RS-SS-LTSS-Intake@co.anoka.mn.us or via fax at: (763) 324-1043. Questions – call (763) 324-1450

Date	Referral Source Name		
Phone	Referral Source Relationship to the Individual		
Client Information			
Name	Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Social Security Number	PMI		
Marital Status <input type="checkbox"/> Single/Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Unknown			
Address			
City	State	ZIP	
Phone Number	County of Financial Responsibility		
Email Address	Preference to be contacted		
Language Spoken	Interpreter Needed <input type="checkbox"/> Yes <input type="checkbox"/> No		
Certified Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No If yes <input type="checkbox"/> Social Security or <input type="checkbox"/> State Medical Review Team (SMRT)			
Program Interest <input type="checkbox"/> AC <input type="checkbox"/> ECS <input type="checkbox"/> EW <input type="checkbox"/> CADI <input type="checkbox"/> CAC <input type="checkbox"/> BI <input type="checkbox"/> DD <input type="checkbox"/> PCA <input type="checkbox"/> CSP Only			
Services Interested in (If questions on program detail, see website: MNHelp.info/MedicaidWaiverPrograms)			
Services Currently Receiving (Include any PCA, Case Management and/or other In-Home Services)			
Current Living Situation			
<input type="checkbox"/> With others, if with others <input type="checkbox"/> Spouse <input type="checkbox"/> Parents <input type="checkbox"/> Young Children <input type="checkbox"/> Adult Children <input type="checkbox"/> Alone <input type="checkbox"/> Assisted Living <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Other			

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

If minor child, please provide parent(s) info Are Parents Biological or Adoptive

Parent Name Date of Birth Second Parent Name Date of Birth

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 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Veterans Benefits <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 & Clinic	Phone Number
Mental Health Provider & Clinic	Phone Number
Home Care Agency & Contact Person	Phone Number
Specialist Provider & Clinic	Phone Number
Other Provider	Phone Number

Diagnosis	
1	2
3	4
Assistance needed in the following areas <input type="checkbox"/> Sitting up/moving around in bed <input type="checkbox"/> Walking <input type="checkbox"/> Oxygen Therapy <input type="checkbox"/> Getting in/out of bed/chair <input type="checkbox"/> Bathing <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Grooming (combing hair, brushing teeth, shaving) <input type="checkbox"/> Eating <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Toileting: any incontinence? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Tube Feedings <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Dressing <input type="checkbox"/> Injections <input type="checkbox"/> IV Therapy <input type="checkbox"/> Other <input type="checkbox"/> Wound Care <input type="checkbox"/> Medication Compliance <input type="checkbox"/> Other	

Referral Reason
Caregiver Need <input type="checkbox"/> Supports requested <input type="checkbox"/> Permanent Loss <input type="checkbox"/> Inability of caregiver / Temporary Loss Comment
Safety Concern <input type="checkbox"/> Falls <input type="checkbox"/> Supervision <input type="checkbox"/> Harmful behaviors Comment
Behavioral or Emotional Concerns <input type="checkbox"/> Yes <input type="checkbox"/> No Comments
Concerns regarding a child's communication, learning or social skills <input type="checkbox"/> Yes <input type="checkbox"/> No Comments
Memory Concerns <input type="checkbox"/> Yes <input type="checkbox"/> No Comments
Housing/Living Arrangements Concerns
Services and Supports <input type="checkbox"/> Current services not adequate <input type="checkbox"/> Education/school/transition <input type="checkbox"/> Modifications <input type="checkbox"/> Specialized equipment and supplies Comments
Other Concerns