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

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

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

Name	Relationship to Client
Address	
City / State / ZIP	
Phone	Email

Emergency Contact

Name	Relationship to Client
Address	
City / State / ZIP	
Phone	Email:

Contact for Scheduling

Name	Relationship to Client
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	Veterans 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 Provider	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	☐ Walking	☐ Oxygen Therapy
☐ Getting in/out of bed/chair	☐ Bathing	☐ Physical Therapy
☐ Grooming (combing hair, brushing teeth, shaving)	☐ Eating	☐ Occupational Therapy
☐ Toileting: any incontinence? ☐ Yes ☐ No	☐ Tube Feedings	☐ Speech Therapy
☐ Dressing	☐ Injections	☐ IV Therapy
☐ Other	☐ Wound Care	☐ Medication Compliance
☐ Other		

Referral Reason

Caregiver Need ☐ Supports requested ☐ Permanent Loss ☐ Inability of caregiver / Temporary Loss
Comments

Safety Concerns ☐ Falls ☐ Supervision ☐ Harmful behaviors
Comments

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