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@anokacountymn.gov 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 ☐ Male ☐ Female

Social Security Number	PMI

Marital Status ☐ Single/Never Married ☐ Married ☐ Widowed ☐ Divorced ☐ Unknown

Address

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 (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

☐ 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 ☐ 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 ☐ 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 & 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

- ☐ 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