Clerk Home Health Care LLC
Referral Form

CLERK HOME HEALTH CARE LLC IS LICENSED UNDER 245D, TO PROVIDE HOME AND COMMUNITY-BASED SERVICES (HCBS) TO MINNESOTA RESIDENTS.
TYPE OF SERVICES WE PROVIDE: HCBS WAIVER SERVICES (BI, CAC, CADI AND DD)/ HOUSING TRANSITIONING AND SUSTAINING

Please note, this is a preliminary data gathering to quickly determine if a referral meets criteria and establish a referral to the correct site if they do.

Send to *Clerkhomehealthcare@gmail.com*

Date Referral Form Submitted:	Service Requested Start Date:
Referring Agency (Hosp, Jail, psych unit, other):	
Person referred by:	Relationship to Person

Reason for the referral:

SERVICE INQUIRY DESCRIPTION

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*We do not offer PCA services**

Type of Service Request:

☐ Adult Companion Supervision	Hours/week_____
☐ Individualized Home Supports (IHS)	Hours/week_____
☐ Individualized Home Supports with Family Training	Hours/week_____
☐ Respite Care in or out of Home	Hours/week_____
☐ Night Supervision	Hours/week_____
☐ In-Home Family	Hours/week_____
☐ In-Home Family Support	Hours/week_____
☐ 24 Hour Emergency Assistance	Hours/week_____
☐ IHS with and without Training	Hours/week_____

Name:	Date of birth:
Address:	Email address:
Cell phone number:	Language(s) spoken:
Guardianship type (self, private, public):	Gender
Marital status:	
FINANCIAL INFORMATION	
Social Security Number (SSN):	Medical Assistance Number:
County of responsibility:	PMI number:
County of financial responsibility:	Waiver Type: (CADI, DD, BI)
MEDICAL INFORMATION	
Diagnoses:	

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Allergies:	
Protocols (seizure, diabetic, etc.):	
Medical equipment, devices, or adaptive aides or technology used:	Specialized dietary needs:

GENERAL CONTACT INFORMATION	
Name	**Address and telephone numbers**
Legal representative:	
Authorized representative:	
Primary emergency contact:	
Case manager:	
CADI Case Manager:	
Financial worker:	
Residential contact:	
Vocational contact:	
Other service provider:	

HEALTH-RELATED CONTACT INFORMATION	
Name	**Address and telephone numbers**
Primary health care professional:	
Psychiatrist:	
Other mental health professional:	
Neurologist:	
Dentist:	
Optometrist/Ophthalmologist:	
Audiologist:	
Pharmacy:	
Hospital of preference:	
Other health professional:	
Other health professional:	

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Please provide supporting documents ☐ CSSP/ISP/CSP ☐ Evaluation/Assessment ☐ Other_____
Message: