

Safe Heaven Home Care Services**Address:** 33 Wentworth Ave E, Suite 395, West Saint Paul, MN

55118

Office: 763-332-9194**Fax:** 763-291-0149**Email:** info@shhcs.org**NPI:** 1104542380**INTEGRATED COMMUNITY SUPPORTS REFERRAL FORM**

Referral Date: _____

Personal Information

First Name:	M.I.:	Last Name:	PMI No:
Date of Birth:	Gender: Male Female Prefer not to answer Other:	Race:	SSN:
Address:		City:	Zip code:
Phone Number:	Cell Number:	E-mail address:	
Diagnosis Codes			

Waiver Case Manager Information

First Name:	Last Name:	
Address:	City:	Zip code:
E-mail Address:		
Office number:	Office Fax:	Office number:
Agency Name:	Would you like to be updated on all assessment scheduling? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Primary Emergency Contact Information

First name:	Last name :
Best Contact Number:	Relationship:

Special Needs

Are there any known cultural consideration needs?	Yes	No	specify: _____
Allergies: _____			
Other (be specific): _____			

Level of Need

Does this person have a criminal background? Yes No

Are you aware of any drug/ alcohol use? Yes No

Does this person use the following? (mark all that apply) Walker Cane Wheelchair

Other: _____

Does this person have an income source? Yes No (If yes, enter information below)

Type of income: _____ Amount: \$ _____

Does this person currently have a lease? Yes No

If so, when will it end? _____

How soon does this person want/need to move? (exact date not necessary) _____

Other important notes (please be specific): _____

Care Preferences

Will this person need Transitional Services? (choose all that apply)

Deposit Movers Household items Furniture

Legal Status & Legal Representative Contact Information

responsible for self under guardianship (complete section below) under commitment

First name:	Last name:	
Address:	City:	Zip code:
Best Contact Number:	Fax Number:	Email:

****At time of referral, we ask that you submit the individuals Face Sheet, CSSP, MNChoice and any other supporting documents (if you have them available) for review**

Case Manager Signature: _____

Date: _____