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| *SPARKLES HOME HEALTH CARE IS LICENSED UNDER 245D, TO PROVIDE HOME AND COMMUNITY-BASED SERVICES (HCBS) TO MINNESOTA RESIDENTS.*  *TYPE OF WAIVER SERVICES WE PROVIDE: HCBS WAIVER SERVICES (BI, CAC, CADI AND DD)*  ***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 sparkleshhc@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** | | |
| Type of Service Request:   * Individual Community Living Support Hours/week\_\_\_\_\_\_\_\_ * 24 hours Emergency Assistance Hours/week\_\_\_\_\_\_\_\_ * Companion Hours/week\_\_\_\_\_\_\_\_ * IHS with training Hours/week\_\_\_\_\_\_\_\_ * IHS without training Hours/week\_\_\_\_\_\_\_\_ * Night Supervision Hours/week\_\_\_\_\_\_\_\_ * Respite care Hours/week\_\_\_\_\_\_\_\_   \*We do not offer PCA services\*\* | | |
|  | | |
| 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: | | |
| 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: |  | |
|  |  | |
|  | | |
| **Please provide supporting documents**   * CSSP/ISP­­­­/CSP * Evaluation/Assessment * Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Message: | | |