|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *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: |