**IZZY HOMECARE REFERRAL FORM**

# Personal Information

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| First Name:  |  | M.I.:  | Last Name:   |  |
| Date of Birth:  | Gender: Male Female  Prefer not to answer  | Race:  | SSN:  |
|  |  |  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Address:  |  | City:  | State: **MN**  Zip:   |
| Phone Number:   |  | Cell Number:   | Work Number:    |

**Reason(s) for Referral (**Please mark all that apply)

 Night Supervision Respite Care

 Homemaker Adult Companion services\_\_\_\_\_\_\_\_

 IHS ~ IHS Type/Hours per week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 24-hr. Emergency Assistance ~ Tier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Independent Living Services ~ ILS Hours per Week: \_\_\_\_\_\_\_\_\_\_\_\_\_

 Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional Information: ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Special Needs

|  |
| --- |
|  Are there any known cultural consideration needs? Yes No specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Is there any gender preference regarding the assigned staff? Yes No If yes: Male Female No preference  Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other (be specific): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |

**Waiver Type:** Brain Injury CAC CADI DD EW

# Insurance Information

|  |  |  |
| --- | --- | --- |
| Primary insurance: (**please check box)**   **UCARE**  MEDICA Health Partners Blue Cross Blue Shield MA Metropolitan Health Plan Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |  Straight  | PMI Number:   Medical Assistance Number:   |
| Primary Ins. # Group #   |  | Other insurance information:    |

# Mental Health Case Manager Information

|  |  |
| --- | --- |
| First Name:   | Last Name:  |
| Address: City: State: **MN**  Zip:  |
| E-mail Address:  |
| Office number:   | Office Fax:  | Cell number:  |
| Agency Name:  | Would you like to be updated on all assessment scheduling & treatment of services? Yes No   |

# Waiver Case Manager Information

|  |  |
| --- | --- |
| First Name:   | Last Name:  |
| Address: City: State: **MN**  Zip:  |
| E-mail Address:  |
| Office number:   | Office Fax:  | Cell number:  |
| Agency Name:  | Would you like to be updated on all assessment scheduling & treatment of services? Yes No  |

 **Referrals and copies of documents can be mailed, or e-mailed to:**

**NPI #: 1437809449**

**Izzy Homecare LLC**

 **Phone: (952) 520-0806 (Main)**

**Phone: (914) 218-0757 (Cell)**

 **1518 E. Lake Street Suite 201C**

**Minneapolis, MN 55407**

**Attn: ADMINISTRATOR**

 **E-mail:** **izzyhomecare@gmail.com**

 **Subject: Referral Form**