AHHC
American Home Health Care

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 ? ☐ Yes ☐ 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): _____

American Home Health Care LLC
Email: info@ahealthcarehome.com Phone: 763-334-6957 Fax: 763-334-6958

AHHC
American Home Health Care

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: $_____
Type of income: _____ Amount: $_____
Type of income: _____ Amount: $_____
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: _____

Submit

American Home Health Care LLC
Email: info@ahealthcarehome.com Phone: 763-334-6957 Fax: 763-334-6958