HealthChoices **900 20th Avenue S, Minneapolis, MN 55404**

 **Adult and/or Child Referral Form** **Phone: (612) 752-8181 Fax: (612) 824-4654**



|  |  |  |  |
| --- | --- | --- | --- |
| *Office Use Only:*  | Date of Referral: | PMAP: | MA#:  |

|  |  |  |
| --- | --- | --- |
| Referring MFIP Agency:      |  | Address:      |
| Employment Counselor:      |  | Phone:      | Fax:      |

|  |  |  |  |
| --- | --- | --- | --- |
| Participant’s Name:      |  | SS #:      DOB:       | Participant has personal Mental Health Concerns:Yes [ ]  No [ ]  |

|  |  |  |
| --- | --- | --- |
| Child(ren)’s Name:      | Child(ren) DOB:        | Child has behavioral/ mental health concerns:Yes [ ]  No [ ]  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Address:      | Maxis #:      | Age:   | Sex:  | Race:     |
| City:      | State:      | Zip Code:      | Phone: (     )     -      | Phone reliable:Yes [ ]  No [ ]   |
| Email Address:      | Participant signature to authorize email / text contact: |
| Would Client prefer a female or male HealthChoices Case Manager? [ ]  No preference [ ]  Female [ ]  Male  |
| Client must meet all four of the following HealthChoices admission criteria, check as applicable:1) [ ]  Suspected MH, LD, or CD Barrier 2) [ ]  ESP Assigned 3) [ ]  MFIP Participant 4) [ ]  Resident of Hennepin County |
| MFIP Months Used:      | Stable Housing:Yes [ ]  No [ ]   | Intent to Sanction: Yes [ ]  No [ ]   | Active Sanction: Yes [ ]  No [ ]   |
| Highest Grade Completed:       | Post-Secondary:Yes [ ]  No [ ]  | GED: Yes [ ]  No [ ]   | Applied for SSI: Parent [ ]  Child [ ]  No [ ]   |
| ***Consent for Release of Information :*** I authorize MFIP (Minnesota Family Investment Program) agency to disclose the above named Hennepin County contracted vendor to provide services and information about me listed on this form for the purpose of enabling the Hennepin County contracted vendor to provide services and assistance to me. I understand that this information is protected under Minnesota State and/or federal data privacy laws and cannot be disclosed without my written consent unless otherwise provided for under state and/or federal law. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on the consent. |

|  |  |
| --- | --- |
| Participant Signature: | Date: |
| Comments / barriers / reason for referral: participant      |
| Comments / barriers / reasons for referral: child(ren)      |
| What strengths, supports or resources does the family have in place already?      |