**Alfa Care Services LLC Services Referral Form:**

**NPI: A368447800**

|  |  |  |
| --- | --- | --- |
| **Select Service Type** |  |  |
| ☐Individualized Home Supports | ☐Personal Support | ☐Individual Community Living Supports (ICLS) |
| ☐Night Supervision | ☐In-Home Family Support | ☐Personal Support |
| ☐Independent Living Skills | ☐Individual Home Support with or without training | ☐Other |
| **“Choice Referrals” Meaning we accept clients that have their own staff. Does client have their own staff? ☐ YES ☐ NO** | | |

**Today’s Date**:      /     /

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **INDIVIDUAL’S INFORMATION** | | | | | | | | | | | | | |
| Full Name: | | DOB (mm/dd/yyyy):      /     / | | | | | | | | Sex: ☐ Male ☐ Female | | | |
| Address: | | | | | | City: | | State: MN | | | | Zip: | |
| Phone #: | MA #: | | | | County: | | | | | |
| Waiver Type/Payment Source: ☐ DD ☐ CADI ☐ CAC ☐ AC ☐ Private Pay ☐ Other (list): | | | | | | | | | | | | | |
| Are Medical Assistance and the waiver currently active? ☐ Yes ☐ No What is the renewal date: | | | | | | | | | | | | | |
| Number of hours per week of services being requested:  **Rate:** | | | Availability:  Please fill out the days of the week, and available times for this person to work with staff. This information is necessary so that we can have staffing available.   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | Day | Sun | Mon | Tue | Wed | Thur | Fri | Sat | | Time |  |  |  |  |  |  |  | | | | | | | | | | | |
| When would you like to start services?      /     / | | | | | | | | | | | | | |
| Guardianship Status: ☐ Self ☐ Other (list name & contact info): | | | | | | | | | | | | | |
| **CASE MANAGER INFORMATION**  Alfa Care Services LLC values the presence, support and input of case managers on the support team. We ask that case managers coordinate and attend the intake meeting of the person being referred. Ensuring the best coordination possible for people taking the step towards full community integration is our goal. | | | | | | | | | | | | | |
| Case Manager Name: | | | | | | | Phone #: | | | | | | |
| County/Agency: | | | | | | | Fax #: | | | | | | |
| Address: | | | | City: | | | | | State: | | | | Zip: |
| Email: | | | | | | | | | | | | | |

**Please fill out the form with as much detail as possible and return with a copy of the most current Coordinated Service and Support Plan (CSSP).**

**Email referral to ALFACARESERVICESLLC@GMAIL.COM**