****

SPD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***ILS & ICLS – MCO Referral Form***

**\**Required lines to fill in below***

**Today’s Date:**

**Name:**

**Is this person able to meet virtually if needed?  Yes  No – If no, what are the barriers?**

**Service requesting:**

**ILS**

**ICLS**

**Housing Type:**  **Apartment/Home**  **Nursing Home**  **Assisted Living**  **Group Home/Foster Home** **Homeless**

**Address:**

**Phone:**

**Email:**

**Primary Disability(ies):**

**Are there currently any animals living in the home of this referral?**  **Yes**  **No**  **Unsure**

* **If Yes, please identify:**

**Own Guardian/Legal Representative:  Yes  No**

**Guardian/Legal Representative Name and Phone Number:**

**Services requesting – please identify what services and areas for outcomes that this consumer would like to or benefit from working on:**

**Any scheduling conflicts to work around? (School/work/treatment/etc.):**

**Are there any specific days or times during the week the person prefers to meet?:**

**County of Residence:**

**Date of Birth:**

**Gender:**  **Male**  **Female**  **Other**

**Referral Source Name and Phone Number:**

**Referral Source Email:**

**Service Authorization (MCO):**  **Medica**  **Health Partners**  **UCare**

**Hours Authorizing:**

**Preference working with a**  **Female or**  **Male staff person or**  **Either**

**Other Information that would be important to know in regards to this referral:**