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SPD:_____

Independent Living Services – Referral Form

Today's Date:

Name:

Type of Referral (Please check which one applies):

☐ **ILS**

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

Home 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**

If 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:

Referral Source Email:

Service Authorization (MCO): ☐ Medica ☐ HealthPartners ☐ UCare

Hours Authorizing:

Staff gender preference: ☐ Female ☐ Male ☐ No Preference

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