Anoka County
HUMAN SERVICES DIVISION
Community Social Services and Behavioral Health

MnCHOICES Assessment Referral Form

PLEASE PRINT! Complete referral form, save, and send as an attachment to Long Term Services and Supports Intake at: RS-SS-LTSS-Intake@anokacountymn.gov or via fax at: (763) 324-1043. Questions? Call (763) 324-1450

Date: _____ *(MM/DD/YYYY)* Person Completing Form: _____ *(First / Last Name)*

Phone: _____ *(###) ###-####* Relationship to Person to be Assessed: _____ *(Required)*

Location of Person to be Assessed

Current Location: ☐ Permanent address *(list below in next section)*, ☐ Hospital, ☐ Other Facility

Hospital/Facility Name: _____ *(Name)* *(City where located)* Admission Date: _____ *(MM/DD/YYYY)*

Discharging Location: ☐ Permanent address *(listed below)*, Anticipated Discharge Date: _____ *(MM/DD/YYYY)*

☐ Other Facility (specify name): _____

Discharging Facility Location: _____ *(City)* *(State-2 letter code)* *(Zip code)* *(County)*

Information of Person to be Assessed

Legal Name: _____ *(First Name / Middle Name / Last Name)* Birth Date: _____ *(MM/DD/YYYY)* Age: _____

Preferred Name / Alternative Names: _____ *(Specify here, if any)*

Permanent Address: _____ *(Street address)* *(Apartment #)* *(City)* *(State-2 letter code)* *(Zip code)*

Phone #: _____ Alternate Phone #: _____ Okay to text: ☐ Yes, ☐ No

Email Address: _____ Preferred Contact method: ☐ Email, ☐ Phone, ☐ Text

SS#: _____ MA Case #: _____ PMI #: _____ CFR: _____

Preferred Language: _____ Interpreter Needed: ☐ Yes, ☐ No

Sex *(choose one)*: ☐ Male, ☐ Female, ☐ Non-Binary, ☐ Other, ☐ Decline to Answer

Marital Status:
☐ Married (living with spouse) ☐ Legal Separation ☐ Divorced ☐ Unknown
☐ Married, involuntarily separated ☐ Never married ☐ Widowed
☐ Married (living apart) ☐ Living with partner ☐ Common law

Ethnicity & Native American Tribal Affiliation

Ethnicity: Describe identified race: _____

☐ Hispanic/Latino, ☐ Not Hispanic/Latino, ☐ Declined to answer.

Native American Tribal Nation Affiliate? ☐ No Affiliation
☐ Yes-Registered with a tribal nation
☐ Yes-Not registered with any tribal nation

If yes, which tribe/s: _____

If yes, who do you want to have conduct the assessment? ☐ Tribe, ☐ County of Location

MINOR Child Information (required if the person to be assessed is 17 years old or younger)

Mother's Name: _____ Birth Date: _____
(Legal) *(First Name / Middle Name / Last Name)* *(MM/DD/YYYY)*

Address: _____
(Street address) *(Apartment #)* *(City)* *(State-2 letter code)* *(Zip code)*

County: _____ Phone #: _____ Okay to text: ☐ Yes, ☐ No

Email Address: _____ Preferred Contact method: ☐ Email, ☐ Phone, ☐ Text

Father's Name: _____ Birth Date: _____
(Legal) *(First Name / Middle Name / Last Name)* *(MM/DD/YYYY)*

Address: _____
(Street address) *(Apartment #)* *(City)* *(State-2 letter code)* *(Zip code)*

County: _____ Phone #: _____ Okay to text: ☐ Yes, ☐ No

Email Address: _____ Preferred Contact method: ☐ Email, ☐ Phone, ☐ Text

Describe any parental situations that require additional clarification:

Adoption: Is this child in the process of being adopted? ☐ Yes, ☐ No, ☐ Unknown

If yes, please provide details:

Legal Decision-Making Authority Information

Is there someone who signs documents for this person or helps this person make decisions about health care, money, or other concerns?

☐ No, client makes their own decisions.

☐ Yes (***check the type/s below and provide the name and contact information of who is providing assistance)***

- ☐ Parent of a minor child (information provided above in previous section)
- ☐ Court ordered legal guardian or legal conservator ***(Please provide a copy of the court order to the county)***
- ☐ Power of Attorney ***(Please provide a copy of the Power of Attorney document to the county)***
- ☐ Responsible Party (not court ordered)
- ☐ Informal decision-making support

Name: _____ Relationship to Person: _____
(First Name / Middle Name / Last Name) *(Specify)*

Address: _____
(Street address) *(Apartment #)* *(City)* *(State-2 letter code)* *(Zip code)*

County: _____ Phone #: _____ Okay to text: ☐ Yes, ☐ No

Email Address: _____ Preferred Contact method: ☐ Email, ☐ Phone, ☐ Text

Other (additional clarification if needed):

Disability / Insurance / Veterans / Financial Status Information

Has this person been certified disabled?
- ☐ No (has not been certified as disabled)
- ☐ Yes (Certified disabled by Social Security)
- ☐ Yes (Certified disabled by SMRT)

Insurance:
- ☐ Medical Assistance (active)
- ☐ Need to apply for Medical Assistance
- ☐ Medical Assistance (pending application)
- ☐ Medicare (Part A) Policy Number: _____
- ☐ Medicare (Part B) Policy Number: _____

☐ Private Insurance (Provider Name): _____

Policy Number: _____

Veteran Status: Is this person a United States military veteran? ☐ Yes, ☐ No, ☐ Unknown

If yes, do they receive VA benefits? ☐ Yes, ☐ No, ☐ Unknown

Financial (check one):
☐ Married (Liquid assets less than or equal to $50,000)
☐ Married (Liquid assets greater than $50,000)
☐ Not Married (Liquid assets less than or equal to $25,000)
☐ Not Married (Liquid assets greater than $25,000)

Comments: _____

Professional Contacts Information (Professionals working with this person)

Case Manager/ Social Worker: _____ *(First Name / Last Name)* Agency Name: _____
Phone #: _____ Email Address: _____

Care Coordinator: _____ *(First Name / Last Name)* Agency Name: _____
Phone #: _____ Email Address: _____

Primary Medical Clinic / Doctor: _____ *(First Name / Last Name)* Agency Name: _____
Phone #: _____ Email Address: _____

Mental Health Provider: _____ *(First Name / Last Name)* Agency Name: _____
Phone #: _____ Email Address: _____

Home Care Agency: _____ *(First Name / Last Name)* Agency Name: _____
Phone #: _____ Email Address: _____

Specialist Provider: _____ *(First Name / Last Name)* Agency Name: _____
Phone #: _____ Email Address: _____

Financial Worker: _____ *(First Name / Last Name)* Agency Name: _____
Phone #: _____ Email Address: _____

Other Provider: _____ *(First Name / Last Name)* Agency Name: _____
Phone #: _____ Email Address: _____

Person Anoka County LTSS should contact to schedule appointments

Name: _____ *(First Name / Middle Name / Last Name)* Relationship to Person: _____ *(Specify)*

Address: _____ *(Street address)* *(Apartment #)* *(City)* *(State-2 letter code)* *(Zip code)*

Phone #: _____ Okay to text: ☐ Yes, ☐ No

Email Address: _____ Preferred Contact method: ☐ Email, ☐ Phone, ☐ Text

Emergency Contact Information

Name: _____ *(First Name / Middle Name / Last Name)* Relationship to Person: _____ *(Specify)*

Address: _____
(Street address) (Apartment #) (City) (State-2 letter code) (Zip code)

Phone #: _____ Okay to text: ☐ Yes, ☐ No

Email Address: _____ Preferred Contact method: ☐ Email, ☐ Phone, ☐ Text

Describe any Health and/or Functional Concerns (this section **MUST** be completed)

1. _____
2. _____
3. _____
4. _____

Assistance Is Needed in the Following Areas (check all that apply and complete all areas of entire section)

☐ Bathing
☐ Dressing
☐ Grooming (hair/teeth/shaving)
☐ Walking
☐ Eating
☐ Sitting up/Moving around in bed
☐ Getting in/out of bed and/or chairs
☐ Toileting (is the person incontinent? ☐ Yes / ☐ No)
☐ Medication Compliance
☐ Wound care
☐ Injections
☐ Tube feedings
☐ Oxygen Therapy
☐ Physical Therapy
☐ IV Therapy

Current Living Arrangement (check all that apply)

☐ Live Alone
☐ Live with parents
☐ Live with other adults
☐ Live with minor children

Describe current living arrangement concerns, if any:

Describe assistance requested:

Describe assistance this person is currently receiving:

Describe any memory concerns:

Describe any behavioral concerns:

Describe concerns regarding communication, learning, and social skills:

Anoka County Human Services
Long Term Services & Supports (LTSS) Intake Unit
Request for MnCHOICES Assessment Referral Form

Permission for Someone to Act on My Behalf

You may authorize another person to act on your behalf. **This person will have the same responsibilities and rights as you regarding your contact with Anoka County, for purposes of completing the LTSS referral form and for the scheduling of your MnCHOICES assessment.** They must be at least 18 years old and know your circumstances to provide the necessary information. The authorized person may be a friend, relative, conservator acting on your behalf, a person authorized by the courts, or a person with your power of attorney.

This person can act for you until you notify any Anoka County LTSS Intake staff that you want this to end, or until the closing of your Anoka County LTSS intake referral, whichever comes first. For additional information or for any questions please ask LTSS Intake staff for more information.

To authorize someone to act on your behalf please provide the information below along with the required signatures. **Both you and the person to act on your behalf must sign and date this form.**

Client Name: _____
(Legal) *(First Name / Middle Name / Last Name)*

Address: _____
(Street address) *(Apartment #)* *(City)* *(State-2 letter code)* *(Zip code)*

Telephone #: _____

AUTHORIZED REPRESENTATIVE / ORGANIZATION

Name: _____

Address: _____
(Street address) *(Apartment #)* *(City)* *(State-2 letter code)* *(Zip code)*

Telephone #: _____ Email Address: _____

I voluntarily give permission for the person/organization and the agency listed above to share information and help with the items listed below. I want the person/organization named to:

- ☐ Discuss private information concerning myself, my medical assistance situation, my needs, and abilities, related to having a MnCHOICES assessment.
- ☐ Fill out forms, give information about me, and report changes that may affect my eligibility.
- ☐ See my financial program records including applications, correspondence, notices, and any other supporting documentation related to MnCHOICES assessment and services for which I may or may not qualify.

CLIENT SIGNATURE

Signature: _____ Signature Date: _____

This Designation continues unless I put in an ending date or notify LTSS Intake staff that I want it to end, or with the closing of this MnCHOICES referral.

Auth Ends Date: _____

SIGNATURE OF AUTHORIZED REPRESENTATIVE

Signature: _____ Signature Date: _____

This institution is an equal opportunity provider.