Mahnomen County Social Services MnCHOICES Assessment Referral Form

Date & Time	Referral Source Name:
Phone:	Referral Source Relationship to Client:

Client Information:

Name:		Date of Birth:
Social Security Number:		PMI:
Race:		Tribal Status:
Marital Status: ☐ Single/ Never Married ☐ Married ☐ Widowed ☐ Divorced ☐ Unknown		
Physical Address:		
City:	State:	Zip:
Mailing Address:		
City:	State:	Zip:
Phone Number:		County of Financial Responsibility:
Email Address:		Preferred Contact Method:
Language Spoken:		Interpreter Needed: ☐ Yes ☐ No
Certified Disabled: ☐ Yes ☐ No If Yes ☐ Social Security or ☐ State Medical Review Team		Sex: ☐ Male ☐ Female
Services Interested In:		
Services Currently Receiving and from what agencies:		

Diagnosis (If Known)

1.	2.
3.	4.

Assistance needed in the following areas:

☐ Sitting up/moving around in bed	☐ Walking	☐ Oxygen Therapy
☐ Getting in/out of bed/chair	☐ Bathing	☐ Physical Therapy
☐ Grooming (combing hair, brushing teeth, shaving)	☐ Eating	☐ Occupational Therapy
☐ Toileting: any incontinence? ☐ Yes ☐ No	☐ Tube Feeding	☐ Speech Therapy
☐ Dressing	☐ Injections	☐ IV Therapy
☐ Other:	☐ Wound Care	☐ Medication Compliance
☐ Other:		

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Seizure Activity: ☐ Yes ☐ No If yes, are they controlled: ☐ Yes ☐ No
Current Living Situation: With Others: ☐ Spouse ☐ Parents ☐ Young Children ☐ Adult Children ☐ Assisted Living ☐ Nursing Facility ☐ Alone ☐ Other:

Legal Authority:

Does the person have someone who signs documents or helps make decisions about health care, money, or other issues? Yes ☐ No ☐ if yes, ☐ Informal decision-making support ☐ Responsible Party ☐ Power Of Attorney (POA) ☐ Guardian ☐ Parent ☐ Other:		
Name:		Relationship To Client:
Address:		
City:	State:	Zip:
Phone:		Email:

Insurance and Financial Status:

Insurance		
Medical Assistance: ☐ On Medical Assistance ☐ Needs to apply to Medical Assistance ☐ Has application; needs to complete and return ☐ Has applied for Medical Assistance, results pending		
☐ Health Plan:		
Private Insurance:	Policy Number:	Effective Date:
Medicare A, B, D	Policy Number:	Effective Date:
Veteran Status: ☐ Yes ☐ No		Veteran's Benfits: ☐ Yes No ☐ Unknown

Referral Reason:

Caregiver need: ☐ Support Requested ☐ Permanent Loss ☐ Inability of caregiver/ Temporary Loss Comments:
Safety Concern: ☐ Falls ☐ Supervision ☐ Harmful Behaviors Comments:
Behavioral or Emotional Concerns: ☐ Yes ☐ No Comments:
Concerns regarding a child's communication, learning, or social skills: ☐ Yes ☐ No Comments:
Memory Concerns: ☐ Yes ☐ No Comments:
Housing/ Living arrangement concerns: ☐ Yes ☐ No Comments:

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Services and Supports: ☐ Current services not adequate ☐ Education/ School/ Transition ☐ Modifications ☐ Specialized equipment and supplies Comments:
Other Concerns:

MnChoices is a voluntary assessment that only the Client or Legal Guardian can accept. If they do, an assessment must take place within 20 days of the acceptance of an assessment.

If client is already receiving PCA services through WE and are requesting additional services i.e. waiver services they may contact the tribe for a MnChoices assessment ONLY IF THEY ARE ENROLLED 983-3286 or they may choose to receive a MnChoices assessment/services through Mahnomen County.

Please note: If a client is enrolled in the White Earth Tribe they have a choice as to what agency they receive waiver services through.

Also, anyone who is living on the reservation is eligible to receive Meals on Wheels, Home Health or Nurse Visits free of charge. (Meals on Wheels is only for those living in the country.) So, if they are requesting one or any of these, they may contact White Earth Tribal Health directly at 218-983-3286 to set these services up. They would not need a MnChoices assessment.

This form can be printed and mailed to:

Attention: Social Services Intake
PO Box 460
Mahnomen MN 56557

This form can printed and faxed to:

Attention: Social Services Intake
218-935-5459

This form can be emailed to:

Tami.Pinske@co.mahnomen.mn.us