Gentle Hearts Services Information Referral Form

Gentle Hearts
SERVICES

Personal Information:

Full Legal Name: DOB:

Current Address: Phone Number:

City, State, Zip: Email Address:

Diagnosis Code: Referral Date:

PMI Number: SSN:

Emergency Contact:

Name: Relationship:

Address: Phone Number:

City, state, zip: Email Address:

Case Manager Information:

Name: Title:

Agency: Phone Number:

Fax Number: Email Address:

Insurance Type:

☐ United Healthcare ☐ Blue Plus ☐ Health Partners:

☐ UCare ☐ IMCare ☐ South Country

☐ Medica ☐ Hennepin Health ☐ PrimeWest

☐ Move By:

Required documentation:

Proof of disability Type:

- ☐ Statement by medical professional
- ☐ State medical review team
- ☐ Over 65 years of age
- ☐ SSI/ SSDI
- ☐ Medical opinion Form

Professional Statement of Need:

☐ **Coordinated services plan**

☐ **MnChoices Assessment or LTCC**

Person-centered plan type:

☐ **Housing Focused Person-centered plan**

☐ **CSSP or Coordinated Care Plan**

Employment Status:

☐ **Employed**

☐ **Unemployment**

*Please Email all referrals to: mmuhumed@gentleheartsservices.org