

Alfa Care Services LLC Services Referral Form:

NPI: A368447800

Select Service Type

- | | | |
|---|---|--|
| ☐ Homemaker/Cleaning | ☐ IHS Without Training | ☐ Individual Community Living Supports (ICLS) |
| ☐ Night Supervision | ☐ IHS With Family Training | ☐ Respite In- Home |
| ☐ IHS With Training | ☐ Employment Services | ☐ Other |

"Choice Referrals" Meaning we accept clients that have their own staff. Does client have their own staff? ☐ YES ☐ NO

Today's Date: / /

INDIVIDUAL'S INFORMATION

Full Name:		DOB (mm/dd/yyyy): / /		Sex: ☐ Male ☐ Female					
Address:		City:		State: MN	Zip:				
Phone #:	MA #:	County:							
Waiver Type/Payment Source: ☐ DD ☐ CADI ☐ CAC ☐ AC ☐ Private Pay ☐ Other (list):									
Are Medical Assistance and the waiver currently active? ☐ Yes ☐ No What is the renewal date:									
Number of hours per week of services being requested: Hours: Rate:		Availability: Please fill out the days of the week, and available times for this person to work with staff. This information is <u>necessary</u> so that we can have staffing available.							
		Day	Sun	Mon	Tue	Wed	Thur	Fri	Sat
		Time							
When would you like to start services? / /									
Guardianship Status: ☐ Self ☐ Other (list name & contact info):									

CASE MANAGER INFORMATION

Alfa Care Services LLC values the presence, support and input of case managers on the support team. We ask that case managers coordinate and attend the intake meeting of the person being referred. Ensuring the best coordination possible for people taking the step towards full community integration is our goal.

Case Manager Name:		Phone #:	
County/Agency:		Fax #:	
Address:	City:	State:	Zip:
Email:			

Please fill out the form with as much detail as possible and return with a copy of the most current Support Plan (SP).

Email referral to ALFACARESERVICESLLC@GMAIL.COM