

Client Referral

Thank you for considering a referral to Residential Services of N.E. MN., Inc. (RSI). The following document requests information that assists with the screening of your client for services.

RSI provides Foster Care, ICF/MR, Board and Lodge, In-Home and ARMHS services to adults and children with a variety of disabilities.

Our residential programs are located primarily in St. Louis County with the majority located in Duluth (15 foster care and ICF/MR homes). Eight additional residential settings are located in Brookston, Cook, Virginia, and Biwabik. RSI also operates seven foster care programs in Region 7E that include the Counties of Pine, Kanabec, Mille Lacs, Isanti, and Chisago.

In addition to our foster care settings, RSI provides In-Home and ARMHS services that are delivered in St. Louis, Lake, Carlton, Mille Lacs, Kanabec, Pine, Isanti and Chisago Counties.

RSI will take referrals from other areas of the state; as well as, other states. We accept a wide variety of referrals, which also includes individuals who have experienced:

- Inadequate or inappropriate placements,
- Repeated failed placements,
- Complex behavioral or medical needs, or
- Long-term or repeated hospitalization or institutionalization.

Please fill out the following pages to the best of your ability and attach any supporting documents that will assist us in determining the level of support for the person you are referring.

You may need a release of information to provide us with the information requested. Please use your agency's form for obtaining such permission.

Once you have completed the attached referral form you may fax or mail to the following:

- By Fax:
 - For programs or services located in Northeastern Minnesota (St. Louis, Lake, Carlton, Cook and surrounding counties)
 - Fax: (218) 727-2893, ATTN: Referrals
 - For programs and services located in East-Central Minnesota (Chisago, Isanti, Kanabec, Mille Lacs, Pine and surrounding counties)
 - Fax: (651) 674-5193, ATTN: Referrals
- By Mail:
 - For Northeastern Minnesota: Residential Services of N.E. MN., Inc.
ATTN: Referrals
1309 Rice Lake Rd, PO Box 3008
Duluth, MN 55803
 - For East-Central Minnesota: Residential Services of N.E. MN., Inc. - Region 7E Office
ATTN: Referrals
5833 Pecan St, Suite A-1
North Branch, MN 55056

Please feel free to call RSI's Referral Line with questions at (218) 733-9225

Client Referral

Facsimile Cover Sheet

To: Residential Services of Northeastern Minnesota

ATTN: Client Referral

Phone: (218) 733-9225

Fax: (218) 727-2893: For programs located in Northeastern Minnesota (St. Louis, Lake, Cook and surrounding Counties)
(651) 674-5193: For program located in Central Minnesota (Chisago, Isanti, Kanabec, Mille Lacs, Pine and surrounding Counties)

From: _____ Agency: _____

Phone: _____ Fax: _____

Re: _____ Date: _____

Cover of _____ pages including cover.

Direct or Route to:

___ Laurie Berner, Program Manager, TBI and SPMI Programs

___ Joel Longtine, Program Manager, TBI and SPMI Programs

___ Jenny Basta, Program Manager, TBI and SPMI Programs; Region 7E

___ Sue Carlsness, Program Manager, DD and MI Programs

___ Travis Dombrovski, Program Manager, FASD

___ Liese Dombrovski, Program Manager, ARMHS

___ Roni Horak, Program Manager, In-Home Supports Program for Children, Adults, and Seniors

___ Other:

Notes: _____

Residential Services of Northeastern Minnesota, Inc.

Client Referral and Screening Document

Demographic Information:

Date: _____ On-Call Supervisor: _____

Client Name: _____

Primary Diagnosis: _____

Secondary Diagnoses: _____

Current Residence: _____

Address: _____

Gender: ____ M ____ F Birthdate: _____

Case Manger _____

Email: _____ Phone: _____

Referring County _____ Date services needed? _____

Referral Information Source: _____

Screeners: _____

Screening Date: _____

MA Number: _____ SSN: _____

Funding types:

Type	Approved	Possible	Type	Approved	Possible
MR/RC Waiver			MA - PCA		
CADI Waiver			ICF/MR		
TBI Waiver			ARMHS		
AC Waiver			CTSS		
EW Waiver			Private Pay		

Physical Accessibility Needs

_____ Wheelchair Accessibility _____ One-Level/No Stairs _____ Other, (Describe Below)

Notes: _____

Summary of Safety and Supervision Needs

Does the person referred have support needs or risks in any of the following areas?

Physical and Medical Health Needs:

- Mobility (uses wheelchair, walker, unsteady gait etc.)
- Health/Medical (serious health conditions requiring skilled nursing care or supervision)
- Special diet
- Assistance with taking medications
- Sensory processing (impaired sight, hearing, touch or sensory processing)

NOTES: _____

Personal and Instrumental Activities of Daily Living

- Dressing Bathing Hygiene Eating Toileting Transfers/Positioning
- Money Management Medical Appts. Out of the Home Supervision

NOTES: _____

Home & Personal Safety

- Requires 24-hour awake supervision
- Requires 24-hour setting with asleep staff
- Requires daily services or checks in private home
- Requires services less often than daily

NOTES: _____

Behavior Support Needs

- Current or History of aggressive behavior towards others
- Current or History of injury to self
- Current or History of property destruction
- Current or History of refusing essential health care (diet, medications, personal care)
- Current or History of Verbal abuse
- Smoking Alcohol Drugs

NOTES: _____

Residential Services of Northeastern Minnesota, Inc.

Legal Rights Restrictions

<input type="checkbox"/> Conservator/Guardian	<input type="checkbox"/> Court-committed to Placement
<input type="checkbox"/> Representative Payee	<input type="checkbox"/> Considered Mentally Ill and Dangerous
<input type="checkbox"/> Minor	<input type="checkbox"/> On Probation
<input type="checkbox"/> Power of Attorney	<input type="checkbox"/> Restraining Order
<input type="checkbox"/> Provisional Discharge from Psychiatric Hospital	<input type="checkbox"/> Felony Conviction

Additional Team Members

Legal Representative

Name: _____ Relationship to Client: _____
Organization: _____
Primary Address: _____
Phone: _____
City: _____ State: _____ Zip: _____ Email: _____

*** Release of Information? Yes | No

Other Contact or Family Member

Name: _____ Relationship to Referral: _____
Organization: _____
Primary Address: _____
Phone: _____
City: _____ State: _____ Zip: _____ Email: _____

*** Release of Information? Yes | No

Other Contact or Family Member

Name: _____ Relationship to Referral: _____
Organization: _____
Primary Address: _____
Phone: _____
City: _____ State: _____ Zip: _____ Email: _____

*** Release of Information? Yes | No