Metro Social Services, Inc.
345 W University Ave Suite A
St. Paul, MN 55103
Phone: (651) 647-0647
Fax: (651) 647-1075

Client Referral Form

Client Information

Client name: (Print) _____ Last Name _____ First Name Date of Birth: _____

Street Address: _____ Home Phone: _____

City: _____ Work Phone: _____

Social Security #: _____ Sex: ❑ Female ❑ Male Age: _____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated ❑ Other_____

Race/Ethnicity: ❑ African-American ❑ African ❑ Asian ❑ Caucasian
❑ Hispanic ❑ Native American ❑ Bi-Racial ❑ Other_____

Contact Information

Parent(s)/Guardians: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Case Manager: _____ Phone: _____ Agency: _____

School Contact: _____ Phone: _____ School : _____

Psychiatrist: _____ Phone: _____ Therapist: _____ Phone: _____

Diagnosis: _____

_____

Payment Options / Insurance Information

❑ Medical Assistance # _____ ❑ Self Pay

❑ PMAP ❑ Medica ❑ Health Partners ❑ BC/BS ❑ U-Care ❑ Other _____

Private Insurance Name: _____ Policy / ID # _____ Group / Plan # _____

Presenting Issues (Why the client is being referred)

Service Requested

Waivered Services
- ❑ Independent Living Skills
- ❑ Family Counseling & Training
- ❑ Respite Care Services
- ❑ In-home Family Support
- ❑ Adult Foster Care

Homecare Services
- ❑ Skilled Nursing
- ❑ PCA
- ❑ Homemaker
- ❑ Medication Management
- ❑ Chore Services

Mental Health Services
- ❑ Individual / Family Skills Training
- ❑ ARMHS Services
- ❑ Psychotherapy
- ❑ Mentoring Services

Service start date: _____ Hours per week authorized: _____ Anticipated length of service: _____

_____ Case Manager/Referring staff _____ Date _____ Contact Number