



Metro Social Services, Inc.

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 St. Paul, MN 55103
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Client Referral Form

Client Information

Client name: _____ Date of Birth: _____
(Print) Last Name First Name (m/d/yyyy)

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 Caucasian Asian
 Native American Hispanic Bi-RacialOther Other _____

Contact Information

Parent(s)/Guardians: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Case Manager: _____ Agency: _____ Phone: _____

School Contact: _____ School: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Therapist: _____ Phone: _____

Others: _____

Diagnosis: _____

Payment Options / Insurance Information

Medical Assistance # _____ Self-Pay _____

MHP Medica Health Partners BC/BS U-Care Policy / ID # _____

Other _____ Policy / ID # _____ Group / Plan # _____

Presenting Issues (Why the client is being referred)

Service Requested

Waivered Services	Homecare Services	Mental Health Services
Adult Foster Care	PCA	ARMHS Services
Respite Care Services	Homemaker	Skills Training (CTSS)
In-home Family Support	Chore Services	Mentoring Services
Independent Living Skills (ILS)	Skilled Nursing	After School Program
South East Asian Program	Medication Management	Individual/family therapy

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

_____ Date _____ Contact Number _____

Case Manager/Referring staff