

***Greater Minnesota Family Services***

2320 Highway 12 Willmar, MN 56201

320-214-9692 Ext. 200 Fax 651-925-0236

REFERRAL FOR FAMILY SERVICES

Name of Client: DOB: Date:

Parents/Legal Guardian: Client M F

Phone (H):

Phone (W)

Address:

Counties:

Siblings: (Name, DOB)

Services Requesting: Family BasedSchool & FamilyEarly Childhood (SEED)

Targeted Case ManagementFamily Group Decision MakingUnsure

School District Child Attending:

If supervisory approval is required by your agency, please have supervisor sign and date here. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Referral (please be specific, listing behaviors/symptoms):

Frequency of Service: Morning (8-12pm)Early PM (12pm-4pm) Evening PM (5pm-9pm)

Pertinent Background Information:

Party Responsible for Payment:

County/Grant: Supervisor Approval: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance

Company:

Phone: MA/ID Number: Policy/Group#:

Secondary Insurance Company: Phone: MA/ID Number: Policy/Group #:

Date of last D/A:

Completed By:

**(Please provide a copy of most recent DA) Agency:**

Referred by:

**Agency:**

**Phone: Email:**