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):

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

Pertinent Background Information:

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____

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: _______________________

(Please provide a copy of most recent DA)

Referred by: _______________________________

Phone: _______________________________

Completed By:___________________

Agency: ___________________________

Agency: ___________________________

Email: ___________________________