



# Greater Minnesota Family Services

2320 Highway 12, Suite 2, Willmar, MN 56201

320-214-9692 (p) 651-925-0236 (f)

## 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:
- |  |  |
|--|--|
| <input type="checkbox"/> Family Based  | <input type="checkbox"/> Outpatient (Chippewa County/Telehealth) |
| <input type="checkbox"/> School & Family   | <input type="checkbox"/> Early Childhood - (SEED Day Program)    |
| <input type="checkbox"/> Family Group  | <input type="checkbox"/> Early Childhood - (In-Home)             |
| <input type="checkbox"/> Targeted Case Management  | <input type="checkbox"/> Family Group Decision Making            |
| <input type="checkbox"/> Open to Telehealth  | <input type="checkbox"/> Art Therapy (St. Cloud)                 |
| <input type="checkbox"/> Intensive In-Home Family Services (Morrison, Stearns, Sherburne & Wright Counties ONLY) |  |
| <input type="checkbox"/> Unsure  |  |

Greater Minnesota Family Services Staff Preferred (Name): \_\_\_\_\_

School District Child Attending: \_\_\_\_\_

If supervisory approval is required by your agency, please have supervisor sign and date below:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for Referral (Please be specific, list behaviors/symptoms):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Pertinent Background Information:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Party Responsible for Payment:

- County/Grant: \_\_\_\_\_
- Primary Insurance  
Company: \_\_\_\_\_  
Phone: \_\_\_\_\_  
MA/ID #: \_\_\_\_\_  
Policy/Group #: \_\_\_\_\_

- Supervisor Approval: \_\_\_\_\_
- Secondary Insurance  
Company: \_\_\_\_\_  
Phone: \_\_\_\_\_  
MA/ID #: \_\_\_\_\_  
Policy/Group #: \_\_\_\_\_

Date of Last DA: \_\_\_\_\_  
(Please provide a copy of most recent DA)

Completed By: \_\_\_\_\_  
Agency: \_\_\_\_\_

Referred By: \_\_\_\_\_  
Phone: \_\_\_\_\_

Agency: \_\_\_\_\_  
Email: \_\_\_\_\_

*If you are making a referral to GM, we will inform you that the referral has been received and forwarded to our staff. If you have not received a response within 2 weeks, please contact Carla or Briedget at 320-214-9692. If services have not begun within 3 months of the original referral, GM will need to discontinue your original referral. You will then need to submit a new updated referral to GM.*