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: _____ (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: _____

_____ _____ _____
Case Manager/Referring staff Date Contact Number