1550 HUMBOLDT AVENUE
WEST ST. PAUL, MN 55118
(651) 450-1802 FAX (651) 450-7923
www.thomasalleninc.com

REFERRAL QUESTIONNAIRE

Thank you for your interest in receiving services from Thomas Allen.

To enable us to begin the referral process, we ask that this Referral Questionnaire be completed by the applicant, the applicant's legal representative, case manager or current residential provider. The applicant or his/her legal representative is to review and sign the questionnaire.

Please answer all questions. If any question is not applicable, indicate 'NA' or 'U' for unknown. Incomplete forms may delay the referral process.

Please return the completed Questionnaire to Thomas Allen at the above address.

Referral Information/Preferences for Services

Applicant Name: ______________________ Date: ______________________

County of Service: ______________________

County of Financial Responsibility (if different): ________________________________

Desired Timeline for Service Initiation: ______________________________________

Type of Service Desired (Check any applicable):

☐ Supportive Living Services – SLS (24-hour waivered services provided in a Corporate/Family Residential setting)

☐ Supportive Living Services – SLS (less than 24-hour waivered services provided in my own home)

☐ In-Home Support Services Including Respite, In-home Family Support OR Personal Supports (services provided in family home or foster care home, less than 24-hour services each day.) (Respite may exceed 24- hours and may be provided in a licensed or non-licensed home or provided in the home of the person receiving services)

☐ Semi-Independent Living Services – SILS (services provided in person's home, with less than 7 days a week contact.)

☐ Intermediate Care Facility – ICF (Supervised Living Facility)

☐ Independent Living Services: Brain Injury (BI) or Community Access for Disability Inclusion (CADI) Waiver (Services provided in person's home with less than 7 days a week contact).

☐ Other/Explain: ____

____

____

NAME: ____________ HOME/DIVISION: ____________

____________ address ____________ telephone

LANDLORD: ____________ address ____________ telephone

SOCIAL SECURITY NUMBER: ____________ ADMISSION DATE: ____________

BIRTHDATE: ____________ BIRTHPLACE: ____________

HAIR COLOR: ____________ EYE COLOR: ____________ RELIGION: ____________

RACE: ____________ MARITAL STATUS: ____________ GUARDIANSHIP STATUS: ____________

PRIMARY DIAGNOSIS/CODE: ____________ SECONDARY DIAGNOSIS: ____________

ALLERGIES: ____________

FINANCIAL RESPONSIBILITY-COUNTY: ____________ SERVICING COUNTY: ____________

PMI #: ____________ MEDICARE #: ____________

MEDICARE D PLAN: ____________ PLAN ID#: ____________ CONTRACT ID #: ____________

OTHER (TYPE & POLICY #): ____________ REPRESENTATIVE PAYEE: ____________

UNEARNED INCOME SOURCES/AMOUNT: ____________

TRANSPORTATION NUMBER: ____________

SERVICE COORDINATION WITH OTHER LICENSE HOLDERS

CONTACT PERSON	ADDRESS	PHONE	SERVICE PROVIDED	SERVICE REQUIRING COORDINATION
			Case Management	CSSP
			Vocational/School	Employment/Education
			Residential	CSSP-A
			Financial	County Financial Benefits
			Social Security	Social Security Benefits

LEGAL REPRESENTATIVES/EMERGENCY CONTACT/CASE MANAGER/OTHER:

RELATIONSHIP	NAME	ADDRESS	TELEPHONE	EMERGENCY CONTACT?
LEGAL REPRESENTATIVE				YES ☐ NO ☐
PRIMARY EMERGENCY CONTACT				YES ☐ NO ☐
CASE MANAGER				YES ☐ NO ☐
FAMILY MEMBER				YES ☐ NO ☐
OTHER				YES ☐ NO ☐

Medical Information

Height: ______________________________ Weight: ______________

Diet: ____________ Known Allergies: ______________________________

Does person have a Do Not Resuscitate (DNR), Do Not Intubate (DNI) or other Advanced Care Directive?

☐ No ☐ Yes – If Yes, a copy will need to be provided prior to admission

Seizure Condition ☐ No ☐ Yes
If Yes, complete Seizure Plan of Care (SR/721)

Smoking (amount/day): ____________

Chronic Medical Problems/Complaints	Current Treatment
1. ______________________________	______________________________
______________________________	______________________________
2. ______________________________	______________________________
______________________________	______________________________
3. ______________________________	______________________________
______________________________	______________________________

Has applicant been hospitalized for illness / injury / surgery? If Yes, explain.

Date	Reason for Hospitalization	Hospital Name and Address

Current Medications / Treatments

Medication/Treatment	Purpose	Dosage	Precautions/Side Effects

MEDICAL SERVICES

	NAME	ADDRESS	TELEPHONE
Hospital			
Clinic / Physician			
Dentist			
Neurologist			
Psychologist			
Psychiatrist			
Eye Doctor/Ophthalmologist			
Audiologist			
Other Specialists: (Indicate type)			

Level of Medication Administration Support:

- ☐ Can take medication independently
- ☐ Requires staff observation
- ☐ Requires verbal reminders to take medication
- ☐ Staff must administer all medication

Other significant past medications: Yes ____________ No _____________

If Yes, list name of medication(s), dose, frequency, and reason for use:

NAME	DOSE	FREQUENCY	REASON

Psychotropic Medication History

Has applicant ever been prescribed a psychotropic medication to alleviate symptoms associated with a mental health diagnosis?

Yes ____________ No _____________

If Yes, complete the following:

Name of Medication	Dose prescribed	Target symptoms/condition for which it was prescribed	Dates of Use	Result

Date of Last DISCUS (Tardive Dyskinesia Assessment): ____________________

Date of Last MOSES (Monitoring of Side-Effects Scale): ____________________

Exam Schedule

Type	Frequency	Date of Last Visit	DUE MO/YR
Physical			
Eye			
Dental			
Neurologist			
Psychiatrist			
Psychologist			

An immunization record will be requested when decision is made to provide services to applicant.

Family History

History of illnesses such as diabetes, high blood pressure, or occurrence of heart attack, stroke or cancer at age 60 or younger.

Relative: ____________________ Problem: ____

Relative: ____________________ Problem: ____

Relative: ____________________ Problem: ____

Will applicant accurately report illness or injury? ☐ Yes - describe method ☐ No - please explain

____

____

Does applicant cooperate with health care providers or medical treatments? ☐ Yes ☐ No

Employment or School History

(Please provide information in chronological order, with most recent information listed first.)

EMPLOYER: ______________________ SUPERVISOR: ______________

ADDRESS: ______________________ TELEPHONE: ______________

OTHER AGENCY INVOLVED: ______________________

JOB COACH (if applicable) ______________________ TELEPHONE: ______________

STARTING DATE: ______________ ENDING DATE: ______________

STARTING WAGE: ______________ HOURS WORKED: ______________

WAGE CHANGES: ______________ ENDING WAGE: ______________

TITLE/DUTIES: ______________________

BENEFITS: ______________ TRANSPORTATION: ______________

REASONS FOR LEAVING: ______________________

COMMENTS: ______________________

EMPLOYER: ______________________ SUPERVISOR: ______________

ADDRESS: ______________________ TELEPHONE: ______________

OTHER AGENCY INVOLVED: ______________________

JOB COACH (if applicable) ______________________ TELEPHONE: ______________

STARTING DATE: ______________ ENDING DATE: ______________

STARTING WAGE: ______________ HOURS WORKED: ______________

WAGE CHANGES: ______________ ENDING WAGE: ______________

TITLE/DUTIES: ______________________

BENEFITS: ______________ TRANSPORTATION: ______________

REASONS FOR LEAVING: ______________________

COMMENTS: ______________________

EMPLOYER: ______________________ SUPERVISOR: ______________

ADDRESS: ______________________ TELEPHONE: ______________

OTHER AGENCY INVOLVED: ______________________

JOB COACH (if applicable) ______________________ TELEPHONE: ______________

STARTING DATE: ______________ ENDING DATE: ______________

STARTING WAGE: ______________ HOURS WORKED: ______________

WAGE CHANGES: ______________ ENDING WAGE: ______________

TITLE/DUTIES: ______________________

BENEFITS: ______________ TRANSPORTATION: ______________

REASONS FOR LEAVING: ______________________

COMMENTS: ______________________

Please be aware that some Thomas Allen homes are a setting for other service providers to offer Employment/DT&H services in the home. Applicants can choose to use the service provider in the home or any community setting that offers these services. Does the applicant prefer to use the Employment/DT&H service provided in the home? Yes NO If no, which Employment/DT&H setting is preferred or being explored: ______________

Financial Information

Assets and / or Current Policies:

Type	Yes	No	Location	Amount	Account #
Checking Account					
Savings Account					
Prepaid Burial Account					
Burial Plot					
Health Insurance					
Life Insurance					
Rental Insurance					

Current Income Sources:

Type	Yes	No	Amount	Payee	When Received
Social Security – RSDI					
SSI					
MSA					
MA (Minnesota Health Care)					
Medicare					
Parents/Family					
Other:					
Other:					

Money Management:

Skill	**Level of Independence**				
	Independent	**A Reminder**	**Verbal Cue(s)**	**Physical Cue(s)**	**Total Assistance**
Coin Identification					
Currency / Bill Identification					
Knows purpose / value of money (purchases or sells items for reasonable amounts of money)					
Carries and stores money or valuables safely					
Has sufficient money when making or ordering purchases					
Savings account use / maintenance					
Checking Writing					
Checking account reconciliation					
Bill paying					
Check depositing					
Budgeting skills					
Processing Personal Mail					

Describe general strengths and needs regarding spending habits, current debts, loans to others, borrowing or theft of money, and other items related to finances:

____
____
____
____
____
____

Personal and Community Safety

Skill	Level of Independence				
	Independent	A Reminder	Verbal Cue(s)	Physical Cue(s)	Total Assistance
Informs caregiver or housemates before leaving without supervision					
Immediately withdraws from painful stimuli (heat, sharp objects, etc.)					
Takes reasonable precautions with strangers					
Practices street safety skills					
Practices bike safety skills					
Travels safely while in vehicles (uses seat belt, etc.)					
Seeks help from a responsible person if lost					
Relates identifying information and presents ID					
Responds to warning devices sighted or sounded to identify dangerous conditions or situations (barricade, tornado, siren, fire alarm, etc.)					
Avoids dangerous machinery					
Avoids dangerous conditions or situations (social, sexual, or environmental)					
Avoids abusive use of tobacco, alcohol, or drugs					
Follows directions in dangerous circumstances					
Uses public transportation (i.e. bus system, taxi, etc.)					

Community Alone Time: ____

Alone Time at Home: ____

MISSING TIME LIMIT: ____

Personal and Community Safety Comments:

___

Mobility / Range of Motion

Does applicant have a medical / physical condition which impairs ambulation, balance, coordination and/ or range of motion?

☐ No ☐ Yes

If Yes, describe adaptive equipment used (i.e. orthopedic shoes, walker, braces, wheelchair, cane, etc.) and level of assistance /supervision needed. Also, indicate names of suppliers and dates purchased/received.

___

Does applicant have any physician-ordered activity restrictions? ☐ No ☐ Yes

Diet Management

Does applicant consume only edible, properly prepared foods and beverages? ☐ Yes ☐ No, explain

___

Does applicant have any chewing or swallowing limitations? ☐ No ☐ Yes, please explain

___

List applicants' food preferences and dislikes:

Preferences: ___

Dislikes: ___

Diet Management (continued)

TASK	LEVEL OF INDEPENDENCE				
	Independent	A Reminder	Verbal Cue(S)	Physical Cue(S)	Total Assist.
Meal Planning					
Cooking					
Eating Balanced Meals – appropriate portion control based on body needs					
Table Manners (use of utensils, glass / cup)					
Eating					
Grocery Shopping					
Uses Stove, Oven, or other kitchen appliances					

Comments:

____

____

Domestic Care

TASK	LEVEL OF INDEPENDENCE				
	Independent	A Reminder	Verbal Cue(S)	Physical Cue(S)	Total Assist.
Cleanup of personal items					
Household cleaning					
Laundering Clothes					

Comments:

____

____

Self Care

TASK	LEVEL OF INDEPENDENCE				
	Independent	A Reminder	Verbal Cue(S)	Physical Cue(S)	Total Assist.
Bathing					
Hair Care					
Tooth Brushing					
Hand Washing					
Toileting					
Dressing – selection (all conditions)					
- putting on					
Menstrual Care (if applicable)					
Shaving					
Nail Care					

Comments:

____

____

Communication

Primary Language: ☐ English ☐ Other: ____________________

Mode used and current level: (check all that apply)

☐ Verbal ☐ Written ☐ Sign Language

☐ Gestures ☐ Communication Device (describe) ____________________

Responds to simple instructions? ☐ Yes ☐ No

Answers verbal questions? ☐ Yes ☐ No

Able to converse and understand others? ☐ Yes ☐ No

Able to use phone independently? ☐ Yes ☐ No

Comments: ____________________

Socialization / Leisure/ Recreation

Favorite indoor leisure pursuits/hobbies: ____________________

Favorite outside/community activities: ____________________

General Personality Characteristics: (check which apply)

☐ Outgoing, extroverted ☐ Sociable ☐ Energetic ☐ Leader

☐ Passive, introverted, shy ☐ Prefers to be alone ☐ Relaxed ☐ Follower

Indicate whether the applicant exhibits the following traits: (check all that apply)

☐ Self-injurious ☐ Verbally aggressive ☐ Physically aggressive ☐ Destroys property

☐ Sexually inappropriate ☐ Passive/easily led ☐ Overly familiar with strangers

Comments: (Discuss frequency & intensity, as well as what might trigger these traits.)

____

CULTURE/VALUES HISTORY

At Thomas Allen, we strive to help you maintain the values and traditions that have been a significant part of your life. Please take some time to answer the following questions.

1. How do you celebrate holidays? Do you have any specific traditions tied to any holiday celebrations?

2. Do you have a religious affiliation? How do you typically observe?

3. What are some favorite activities that you share with family and/or significant others:

4. Are there any individuals you would want to stay in contact with? (via, visits, letters, phone contacts?) Please include address, phone numbers (including home and mobile), and email.

______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________

5. Are there any birthdays/anniversaries that we should be aware of? What are your expectations with regard to observing family birthdays? (e.g., to whom would you like to send cards?) Please include addresses, phone numbers (including home and mobile), and email.

______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________

6. How do you typically celebrate birthdays?

7. What is your typical daily routine (from the time you wake until you go to bed)?

8. If you are moving into a home owned by Thomas Allen or FC Subcontractor, you have the right to use a lock on your bedroom door. Do you have an assessed need where a lock on your bedroom door would pose a health or safety risk?

☐ No;

☐ No; but I choose to not use the lock and would prefer to not have a lock on my bedroom door.

☐ Yes; describe how having and/or using a lock on your door would be a health or safety risk:

9. Is there anything that we have missed? Please explain.

DATA COLLECTION NOTIFICATION

The Minnesota Data Privacy Act requires that we inform you that the information we have asked you to provide is necessary for the effective administration of the services for which you are applying.

The information collected will only be used by authorized agency personnel. Use of this information for purposes other than explained herein will not be made without your prior approval, unless such other use if specifically authorized by law.

You also have a right to review any information which is maintained by this agency about you.

SIGNATURES

______________________________ APPLICANT ______________ DATE

______________________________ LEGAL REPRESENTATIVE ______________ DATE

OTHER: ______________ RELATIONSHIP TO APPLICANT ______________________ SIGNATURE ______________ DATE