



Case Manager's Recipient Information Form

Version 1: 7/7/15

Purpose:

When the case manager is not the certified assessor, this document is used to provide information about the recipient from the case manager to the certified assessor for the person's reassessment. This form will be used for the initial reassessment in MnCHOICES.

This is a fillable form document in Microsoft Word. An accessible version will be coming out in the near future and will be posted to CountyLink. This document can be saved and reused as needed. Note: in the future, this will be a DHS eDoc form.

Demographic Information: (client)

First Name:		Middle Name:		Last Name:	
DOB:	Gender:	Marital Status:		PMI#:	
Address: Physical Location/Home(if different)					
Street:					
City:		State:	Zip:	County:	
Directions/Comments:					
Phone Numbers:		Home:		Cell:	
E-Mail					
Preference to be contacted:					

Reason for Contact and Referral Source:

What is the reason for your call today?		Reassessment	Service Agreement Span:		
Referral Date: (Date CM made request for reassessment):					(MM/DD/YR)
Case Manager: (caller)		First Name:		Last Name:	
Address:	Street:				
City:		State:	Zip:	County:	
Phone Numbers:		Work:		Cell:	
E-Mail					

Lead Agency and Communication Information:

County of Service (COS):		County of Residence (COR):			
County of Financial Responsibility (CFR):		LTCC Agency:			
Is client Spanish/Hispanic/Latino descent:					
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unable to determine-abandoned child <input type="checkbox"/> declined <input type="checkbox"/> unknown					
Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Caucasian <input type="checkbox"/> Unknown <input type="checkbox"/> Declined					
Primary language:					
Is an interpreter needed? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the person being assessed need any additional accommodations? <input type="checkbox"/> Yes <input type="checkbox"/> No					

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Decision-Making and Emergency Contact

Does the person have someone who helps make decisions about health care, money or other issues who does NOT have legal or official authority? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Informal decision-making support <input type="checkbox"/> Responsible party <input type="checkbox"/> Other	
First Name:	Last Name:
Phone Number:	Relationship:
Does the person have someone who signs documents or makes decisions about health care, finances or other issues who HAS legal or official authority? <input type="checkbox"/> No <input type="checkbox"/> Yes (See Table)	
If client <18, or as appropriate, provide parent demographics	
First Name:	Last Name:
Phone Number:	Relationship:
Are the parent(s) the legal representatives? <input type="checkbox"/> No <input type="checkbox"/> Yes	

<p>Commitment</p> <p>Name: Address</p>	<p>Has a copy of the legal paperwork been obtained? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Commitment for: <input type="checkbox"/> CD <input type="checkbox"/> DD <input type="checkbox"/> MH</p>
<p>Conservator for finances/property only</p> <p>Name: Address:</p>	<p>Has a copy of the legal paperwork been obtained? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>
<p>Guardian Ad Litem</p> <p>Name: Address:</p>	<p>Has a copy of the legal paperwork been obtained? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Organization: Phone Number: City State Zip</p>
<p>Health Directive Agent</p> <p>Name: Address:</p>	<p>Has a copy of the legal paperwork been obtained? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Organization: Phone Number: City State Zip</p>
<p>Power of Attorney</p> <p>Name: Address:</p>	<p>Has a copy of the legal paperwork been obtained? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Organization: Phone Number: City State Zip</p>
<p>Private Guardian</p> <p>Name: Address:</p>	<p>Has a copy of the legal paperwork been obtained? <input type="checkbox"/> Paid <input type="checkbox"/> Unpaid</p> <p>Type: <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Organization: Phone Number: City State Zip</p>
<p>Public Guardian</p> <p>Name: Address:</p>	<p>Has a copy of the legal paperwork been obtained? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Type: <input type="checkbox"/> Adult <input type="checkbox"/> Juvenile</p>



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	Organization: Phone Number: City State Zip
Representative Payee Name: Address:	Has a copy of the legal paperwork been obtained? <input type="checkbox"/> No <input type="checkbox"/> Yes Organization: Phone Number: City State Zip

Does the person have a Healthcare Directive? Yes No Unsure

Emergency Contact:		
First Name:	Last Name:	
Phone Number:	Email:	Relationship:

Health Insurance, Payers & Providers

Is the person certified disabled by Social Security or through the State Medical Review Team (SMRT) process? <input type="checkbox"/> Yes <input type="checkbox"/> No
Type of Certification: <input type="checkbox"/> SMRT <input type="checkbox"/> SSA
Is the person on medical assistance? <input type="checkbox"/> No <input type="checkbox"/> No, applied and found not eligible <input type="checkbox"/> Yes Date verified in MMIS <input type="checkbox"/> Pending
Eligible for Medical Assistance Payment for Long-Term Care Services? Form DHS-3543) <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown Effective Date:
Does the individual have any type of health insurance or pay sources? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure

TYPE	POLICY NUMBER	EFFECTIVE DATE
Medical Assistance		
Medicare- Part A		
Medicare- Part B		
Medicare- Part D		
Long Term Care Insurance		
Managed Care		
Private		
Veterans		
Other		

Veteran? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Chose not to answer

Health Care Providers Name/Clinic	Location/Address	Phone #	Comments
Primary Physician			
Psychiatrist			
Psychologist			
Specialty Clinic			
Dentist			
Pharmacy			



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Home Care Agency			
Targeted Case Manager			
Other:			

Comments:

What will facilitate the client's receptiveness to the assessment and honor preferences? Include information pertaining to the following items:

1. *Any issues with contacting client, i.e. - answering machine, easiest time of day, only through email etc.*
2. *Who else do you believe the person would like to have present for the reassessment, beyond those required? (assessor will confirm with the person prior to inviting)*
3. *How do present services or supports address the person's assessed needs or mitigate safety issues?*
4. *Are there issues that need to be addressed that the person may not share with the certified assessor?*
5. *Provide information regarding changes in services (frequency, amount or type) since the last assessment based on an appeal decision.*

Staff Warning:

Specifics to client situation:

e.g., Large dog kept in kennel; smoker, etc.