Northern Lights Community Residence
921 Atlantic Ave
Thief River Falls, MN 56701
Phone: (218) 681-8706
Fax: (218) 681-2816

SANFORD HEALTH

IRTS Case Manager Referral Information

Please attach current LOCUS, Diagnostic Assessment, and Functional Assessment if available.

Date: _____

Referral Source Name: _____ Phone: _____

Referring Agency: _____ Fax: _____

Case Manager if different than referral source: _____

County of Responsibility: _____ Phone: _____

Recipient Information

Recipient Name: _____ DOB: _____
First Middle Last

Phone: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Home Address: ☐ Current ☐ Last Known ☐ Homeless ☐ Unknown SSN: _____

_____
Street Apt City State Zipcode

Current Placement: ☐ Home ☐ Sanford TRF Inpatient ☐ Prairie St. John's ☐ Red River Behavioral Health
☐ Altru Hospital ☐ CBHH: _____ ☐ Other Inpatient: _____
☐ Foster/Group Home: _____ ☐ Other: _____

Current Placement Contact: _____ Phone: _____

Legal Status: ☐ Voluntary ☐ Commitment ☐ Stay of Commitment ☐ Guardianship: _____

Community Psychiatric Provider: _____
Name Clinic

Clinical Impression/Diagnosis:_____

_____

Reason for Placement: _____

_____

_____

_____

Goals for Placement: _____

_____

_____

_____

_____

_____

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Additional Information Pertinent to IRTS Placement (support system, cultural considerations, etc.):

_____

_____

_____

_____

Financial Information

Monthly Gross Income: _____ Reductions to Income: _____

Income Source(s): ☐ Employment ☐ Unemployment Insurance ☐ VA Disability ☐ Workmen's Compensation
☐ GA ☐ GMAC ☐ RSDI ☐ SSI ☐ Social Security Pending ☐ Retirement Fund

Employer if applicable: _____

Current Housing Resources: ☐ Section 8 (HUD) ☐ Bridges ☐ Crisis Housing Fund ☐ Other: _____
☐ Application Approved ☐ Application Approval Pending ☐ Need to Complete Application

Recipient GRH Contribution to IRTS: ☐ Recipient is aware and agrees ☐ Recipient is aware disagrees

Recipient: ☐ is own payee ☐ has third party payee: _____
Payee Name and Phone

Funding Source

Programming Funding Source: ☐ Insurance ☐ Rule 12 Funds (Documented Approval Needed) ☐ Other: _____

Insurance Type: ☐ MA ☐ MA Pending ☐ SMRT Pending ☐ Minnesota Care ☐ PMAP ☐ Commercial or Private

MA PMI#: _____ Effective/Anticipated Effective Date: _____

Insurance Company: _____

ID#: _____ Group #: _____ Prior Authorization Required? ☐ Yes ☐ No

THE FOLLOWING INFORMATION WILL BE REQUIRED PRIOR TO INTAKE:

- Copy of the court findings, if a recipient is on a full commitment or stay of commitment, which indicate the type of commitment as well as a copy of the provisional discharge;
- Copy of the completed NLCR "Preadmission Medical and Physical Requirements" form or equivalent current physical exam (within 30 days), to include medical history, immunization record, and a statement the individual is free of communicable disease, signed by a physician or qualified nurse practitioner; and
- Three day supply of medication and current prescriptions for all medications or confirmation from the local pharmacy that the prescriptions have been received and the pharmacy is able to fill the prescriptions, (NLCR uses Thrifty White Drug in Thief River Falls, 218-681-3132).