



7269 Zane Court North  
Brooklyn Park, MN 55429

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**IHS (Individualized Home Support) Referral Form      Date:**

**NPI #: A968962000**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone: \_\_\_\_\_ SS#: \_\_\_\_\_

PMI/MA#: \_\_\_\_\_

SPEND DOWN? Yes  No

If yes, has the client agreed to pay the spend down for IHS? YES  No

DIAGNOSIS: \_\_\_\_\_

PHYSICIAN'S NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME OF CLINIC: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

SOCIAL WORKER/CASE MANAGER: \_\_\_\_\_

PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

Is there a gender preference regarding the assigned staff? NO  Male  Female

Other information or concerns:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_

PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

IHS START DATE: \_\_\_\_\_ IHS END DATE: \_\_\_\_\_

AUTHORIZED IHS HOURS PER WEEK: \_\_\_\_\_