LEO A HOFFMANN CENTER
Hope. Opportunity. Change.

1715 Sheppard Drive - P.O. Box 60 • St. Peter, MN 56082
Telephone: (507) 934-6122 • FAX: (507) 361-6504
www.hoffmanncenter.org prtfreferrals@hoffmanncenter.org

PRTF REFERRAL GUIDELINES

Please fill out completely and return to Leo A. Hoffmann Center with referral information.
Thank you! Date: _____

Client's Name: _____
First Middle Last name
Current Placement: _____

City/State/Zip Code: _____

Date of Birth: _____Height & Weight: _____

Social Security #: _____ Religious Affiliation: _____

Ethnic/Cultural Preference: _____Preferred Pronouns: _____

Glasses? **___Yes ___ No** Braces? **___Yes ___ No**

Guardian Name: _____

Telephone: _____Email: _____

Address: _____

City/State/Zip Code: _____

Guardian Name: _____

Telephone: _____Email: _____

Address: _____

City/State/Zip Code: _____

Any restrictions on either parents' involvement? If so, what? _____
_____

Who is the Legal Guardian/Advocate of the client? _____

Address: _____
Telephone/Email: _____

Who has custody of the client? _____
Parental Rights Terminated? ___Yes ___ No

Sibling(s) Name:	Age:	Relationship:	Sibling(s) Name:	Age:	Relationship:

Chronological List of Treatment Services Received and/or Previous Out-of-Home Placements

_____ _____

_____ _____

_____ _____

_____ _____

Criminal Charges:		
Specific Charge:	**Adjudicated? Y N**	**Date**
1.		
2.		
3.		
4.		

Is the client required to be registered with the BCA as a sex offender? ____ **Yes** ____ **No**

Has this been completed? ___Yes ___ No

PRIMARY TREATMENT CONCERNS (we are not a sex specific or dual diagnosis program):

☐ **Mental Health Symptoms** ☐ **Chemical Dependence** ☐ **Sexual Problematic Behaviors**

List Concerns/Symptoms: _____

_____

Physical Aggression? ___Yes ___ No If yes, towards whom:_____

Property Destruction? ___Yes ___ No If yes, what:_____

Suicidal Ideation/SIB? ___Yes ___ No If yes, when was most recent:_____

Is 1:1 staff to client ratio needed? ___Yes ___ No

REQUESTED PLACEMENT IS: ☐ **Court Ordered** ☐ **Voluntary**

Discharge Plans after PRTF: _____

_____

CURRENT MEDICATION THIS CLIENT IS PRESCRIBED:
(Please bring *at least* a 30-day supply of medication along with you on day of admission.)

Medication	Prescribed by:	Address/Phone #:

Any known allergies or relevant medical/physical/mobility concerns/enuresis or encopresis?

IQ LEVEL:	

Please Include the Following with the Referral Material:

- Recent Psychological/Diagnostic Assessment (no later than 180 day old, has to include medical necessity statement for PRTF level of care, and CASII)
- Police Reports
- Copy of Court Orders
- School Records (IEP)
- Psych. Evaluations/Reports
- MA ONLY: DHS 7696 Form completed by mental health professional turned into AFMC for approval.

A Diagnostic Assessment must be enclosed. We may not do a placement without this assessment. *

Person Making Referral:

Name: _____ **Telephone**: _____

Agency: _____ **Fax**: _____

_____

_____ **Email:** _____

Please list other Court Service/Social Service/Guardian Ad Litem/Dispositional Advisor individuals involved in this case:

Name: _____ **Telephone**: _____

Agency: _____ **Fax**: _____

_____

_____ **Email:** _____

Insurance & Medical Assistance Information Form

Client Name _____ Date of Birth: _____

Client SSN: _____ Date of Admission: _____

☐ I DO NOT HAVE ANY MEDICAL/HEALTH INSURANCE COVERAGE.

Please give us all the pertinent information regarding your insurance coverage. If you have coverage by more than one insurance policy please give information for all policies. This information is needed for our medical/dental providers to file insurance claims. Some insurance companies *will not accept claims without the insured's date of birth*. Please fill in all information requested. If this information is not submitted, Hoffmann Center will bill the county for all medical expenses until all required insurance information is received. Please bring a copy of *both the front and back* of all insurance and Medical Assistance cards or the original cards to admission.

Please note Leo A. Hoffmann Center bills insurance on residential clients only

PRIMARY INSURANCE CARRIER

Plan Name
Address _____
_____
Telephone #_____
Name of Insured _____
Relationship to Patient_____
Birthdate of **Insured** _____
Insured ID Number_____
Group/Account Number_____
Name of Insured's Employer _____
_____
Effective Date_____

MEDICAL ASSISTANCE

Medical Assistance #_____

SECONDARY INSURANCE CARRIER

Plan Name _____
Address _____
_____
Telephone #_____
Name of Insured _____
Relationship to Patient_____
Birthdate of Insured _____
Insured ID Number_____
Group/Account Number_____
Name of Insured's Employer _____
_____
Effective Date_____

OTHER INSURANCE CARRIER(Dental, etc.)

Plan Name _____
Address _____
_____
Telephone #_____
Name of Insured _____
Relationship to Patient_____
Birthdate of Insured _____
Insured ID Number_____
Group/Account Number_____
Name of Insured's Employer _____
_____
Effective Date_____

RELEASE OF INFORMATION

I, _____ authorize Leo A. Hoffmann Center, Inc. to exchange the following information with:

_____, _____
(Name) **(Agency)**

_____
(Address)

_____ _____
(Telephone Number) **(Fax Number)**

Regarding: _____ _____
Name – Last, First, MI Date of Birth

1a. Type of information to be disclosed.

X	Medical Records	☒	Educational Records
☒	Psychological Testing	☒	Case Progress Reviews/Reports
☒	Psychiatric Assessment/Reports/Notes	☒	Social History/Assessments
☒	Court Records	☒	Psychotherapy Notes
☒	Exchange of verbal communication	☐	Substance Abuse/Dependency

☐ Exchange of other specific information (i.e. polygraphs or photographs). Specify information to be exchanged:

_____

b. Are there any limitations to the release of information? ☐ Yes ☐ No
If yes, please specify: _____

_____

2. Purpose or need for disclosure.

X further medical care ☐ legal investigation ☐ insurance ☐ personal
☐ evaluation ☐ To obtain immunization records/general medical records
☒ To coordinate the treatment planning process ☐ Other: _____

3. This authorization may be revoked in writing at any time prior to the disclosure of this information. This authorization will expire no more than one year from the date of your signature below. Revocation of this authorization must be made in writing to: Leo A. Hoffmann Center, Inc. 1715 Sheppard Drive • P.O. Box 60 • St. Peter, Minnesota 56082

By signing this authorization, you understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on you signing this authorization. When the following information is used or disclosed by the authorized recipient, this information may be subject to re-disclosure and is no longer protected. You also have the right to inspect and receive a copy of the material to be disclosed and **copies of records may be obtained with reasonable notice and payment of copying costs.**

_____ _____
Parent/Legal Guardian Signature **Date**

If signed by a person other than the client, state relationship and authority to do so.
☐ Client is Legal Authority ☐ Minor ☐ Legal Guardian ☐ Biological Parent of Minor ☐ Other: _____

_____ _____
Client Signature (if of legal age and no guardianship assigned) **Date**