Referral

Thank you for considering a referral to Residential Services Inc. (RSI). The following document requests information that assists with the screening of person being referred for services.

RSI provides Adult Foster Care, Child Foster Care, Board and Lodge, In-Home, ARMHS and Outpatient Counseling services, including Equine Assisted Psychotherapy and Equine Assisted Learning to adults and children with a variety of disabilities.

Our residential programs are located primarily in St. Louis County with the majority located in Duluth (15 adult foster care and ICF/MR homes). Eight additional residential settings are located in Brookston, Cook, Virginia, and Biwabik. RSI also operates seven adult foster care programs in Region 7E that include the Counties of Pine, Kanabec, Mille Lacs, Isanti, and Chisago.

In addition to our foster care settings, RSI provides In-Home, ARMHS and Outpatient Counseling Services that are delivered throughout St. Louis, Lake, Carlton, Mille Lacs, Kanabec, Pine, Isanti, Chisago and Itasca Counties. Call for details.

RSI accepts referrals from other areas of the state, as well as other states. We accept a wide variety of referrals, which may include individuals who have experienced:

- Inadequate or inappropriate placements,
- Repeated failed placements,
- Complex behavioral or medical needs, or
- Long-term or repeated hospitalization or institutionalization.

Please fill out the following pages to the best of your ability and attach any supporting documents that will assist us in determining the level of support for the person you are referring.

You may need a release of information to provide us with the information requested. Please use your agency’s form for obtaining such permission.

Once you have completed the attached referral form you may fax or mail to the following:

- **By Fax:**
  - For programs or services located in Northeastern Minnesota (St. Louis, Lake, Carlton, Cook and surrounding counties)
    - Fax: (218) 727-2893, ATTN: Referrals
  - For programs and services located in East-Central Minnesota (Chisago, Isanti, Itasca, Kanabec, Mille Lacs, Pine and surrounding counties)
    - Fax: (651) 674-5193, ATTN: Referrals

- **By Mail:**
  - For Northeastern Minnesota: Residential Services of NE MN, Inc.
    ATTN: Referrals
    2900 Piedmont Avenue
    Duluth, MN 55811-2915
  - For East-Central Minnesota: Residential Services of NE MN, Inc. – Region 7E Office
    ATTN: Referrals
    38625 14th Avenue
    North Branch, MN 55056

Please feel free to call RSI’s Referral Line with questions at (218) 733-9225 Ext. 2
Referral for Services

Facsimile Cover Sheet

To: Residential Services of NE MN, Inc. (RSI)

Regarding: Referral for Services

Phone: (218) 733-9225 Ext. 2

Fax: (218) 727-2893: For programs located in Northeastern Minnesota (St. Louis, Lake, Cook and surrounding Counties)

(651) 674-5193: For program located in Central Minnesota (Chisago, Isanti, Itasca, Kanabec, Mille Lacs, Pine and surrounding Counties)

From: ____________________________ Agency: ____________________________

Phone: __________________________ Fax: __________________________

Re: ____________________________ Date: __________________________

Number of _______ pages including cover.

Direct or Route this Referral to:

___ RSI – General (Will be Routed to the Appropriate Program Manager)
___ Jenny Basta, Regional Program Director, BI and MI Programs; Region 7E
___ Nicole Lind, Regional Program Director, BI and MI Programs, Board and Lodge; Iron Range
___ Sue Carlsness, Program Manager, DD and BI Programs; Duluth
___ Liese Dombrowski, Program Manager, ARMHS, Outpatient Counseling Services; Duluth
___ Sheila Fetters, Program Manager, DD and MI Programs; Duluth
___ Roni Horak, Program Manager, In-Home / Respite Program for Children; Duluth
___ Joel Longtine, Program Manager, BI and MI Programs and In-Home Program for Adults; Duluth
___ Crystal Maki, Program Manager, BI and MI Programs; Region 7E
___ Terri McGillvrey, Regional Program Director, DD, BI and MI Programs; Duluth
___ Gigi Toman, Program Manager, ICF/DD and FASD; Duluth

Notes: See also ‘Mental and Behavioral Health Crisis Response Policy’________________________

________________________________________________________________________

________________________________________________________________________
**Referral Form**

**Demographic Information:**

Date: ______________________

**Person’s Name:** ____________________________________________________________

Primary Diagnosis: ____________________________________________________________

Secondary Diagnoses: __________________________________________________________

Current Residence: __________________________________________________________________________________________

Address: ________________________________________________________________________________________________

Gender: _____ M _____ F Birthdate: ________________________________

**Case Manager:** ________________________________________________________________

Email: ___________________________________________________ Phone: _______________________

Referring County: ______________________________ Date services needed? __________________________

How did you hear about RSI? ____________________________________________________________

**Funding Types:**

<table>
<thead>
<tr>
<th>Type</th>
<th>Approved</th>
<th>Possible</th>
<th>Type</th>
<th>Approved</th>
<th>Possible</th>
</tr>
</thead>
<tbody>
<tr>
<td>DD Waiver</td>
<td></td>
<td></td>
<td>ARMHS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CADI Waiver</td>
<td></td>
<td></td>
<td>Private Pay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BI Waiver</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AC Waiver</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EW Waiver</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Physical Accessibility Needs**

Wheelchair Accessibility _____ One-Level/No Stairs _____ Other, (Describe Below) _______

Notes: ________________________________________________________________________________

______________________________________________________________________________________

**For RSI Use Only:**

Person Taking Referral Call: __________________________________________________________

Screening Date: _____________________

Screeners: ____________________________
### Summary of Safety and Supervision Needs

Does the person referred have support needs or risks in any of the following areas?

#### Physical and Medical Health Needs:

- [ ] Mobility (uses wheelchair, walker, unsteady gait etc.)
- [ ] Health/Medical (serious health conditions requiring skilled nursing care or supervision)
- [ ] Special diet
- [ ] Assistance with taking medications
- [ ] Sensory processing (impaired touch or sensory processing)
- [ ] Sight
- [ ] Hearing
- [ ] Speech

**NOTES:**
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

#### Personal and Instrumental Activities of Daily Living

- [ ] Dressing
- [ ] Bathing
- [ ] Hygiene
- [ ] Eating
- [ ] Toileting
- [ ] Transfers/Positioning
- [ ] Money management (Need for assistance in safeguarding cash resources)
- [ ] Medical appointments
- [ ] Out of the home supervision
- [ ] Ability to manage activities of daily living: ________________________________

**NOTES:**
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

- [ ] Need for family and community involvement ________________________________

**NOTES:**
____________________________________________________________________________

- [ ] Need for community, social, or health services ________________________________

**NOTES:**
____________________________________________________________________________
____________________________________________________________________________

#### Home & Personal Safety

- [ ] Requires 24-hour awake supervision
- [ ] Requires 24-hour setting with asleep staff
- [ ] Requires daily services or checks in private home
- [ ] Requires services less often than daily
- [ ] Need for protection

**NOTES:**
____________________________________________________________________________
____________________________________________________________________________
Behavior Support Needs

- ___ Current or History of aggressive behavior towards others
- ___ Current or History of injury to self
- ___ Current or History of property destruction
- ___ Current or History of refusing essential health care (diet, medications, personal care)
- ___ Current or History of Verbal abuse
- ___ Smoking _____ Alcohol _____ Drugs _____

Impairments of judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life:

________________________________________________________________________

NOTES:

________________________________________________________________________

Employment/Education

- ___ Need for vocational skill development
- ___ Need for education
- ___ Need for employment

NOTES:

________________________________________________________________________

Legal Rights Restrictions

- ___ Conservator/Guardian
- ___ Court-committed to Placement
- ___ Representative Payee
- ___ Considered Mentally Ill and Dangerous
- ___ On Probation
- ___ Power of Attorney
- ___ Restraining Order
- ___ Provisional Discharge from Psychiatric Hospital
- ___ Felony Conviction

NOTES:

________________________________________________________________________

Additional Team Members

Legal Representative

Name: _____________________________ Relationship to Referred Person: _______________________

Organization: ________________________

Primary Address: ______________________

Phone: _______________________________

City: _____________________ State: _______ Zip: _________ Email: _______________________

*** Release of Information? Yes | No
Other Contact or Family Member

Name: __________________________________ Relationship to Referred Person: ______________________

Organization: __________________________________________

Primary Address: _______________________________________

Phone: ________________________________________________

City: ___________________ State: _____ Zip: ___________ Email: ________________________________

*** Release of Information? Yes | No

Other Contact or Family Member

Name: __________________________________ Relationship to Referred Person: ______________________

Organization: __________________________________________

Primary Address: _______________________________________

Phone: ________________________________________________

City: ___________________ State: _____ Zip: ___________ Email: ________________________________

*** Release of Information? Yes | No