Dignified Living
HOME CARE

Select Service Type

☐ Individualized Home Supports
☐ Individualized Home Supports w/training
☐ Individualized Home Supports w/family training
☐ Individual Community Living Supports (ICLS)
☐ Other

"Choice Referrals" Meaning we accept clients that have their own staff. Does client have their own staff? ☐ YES ☐ NO

INDIVIDUAL'S INFORMATION			
Full Name:	DOB (mm/dd/yyyy):		Sex: ☐ Male ☐ Female
Address:	City:	State: MN	Zip:
Phone #:	Email:	MA #:	County:
Waiver Type/Payment Source: ☐ DD ☐ CADI ☐ AC ☐ Private Pay ☐ Other (list):			
Are Medical Assistance and the waiver currently active? ☐ Yes ☐ No	What is the renewal date:		

Number of hours per week of services being requested / Additional details:

Availability:
Please fill out the days of the week, and available times for this person to work with staff. This information is necessary so that we can have staffing available.

Day	Sun	Mon	Tue	Wed	Thur	Fri	Sat
Time							

Please describe the services / care you are looking for:

When would you like to start services?

Guardianship Status: ☐ Self ☐ Other (list name & contact info):

How did you hear about us:

Please provide the following documents:
Support Plan
Individual Abuse Prevention Plan (IAPP)
Self Management assessment (SMA)

Email referral to: Referrals@Dignified-Living.com