Referral for Services

Please complete as much information below as possible.

Client Last Name:	**Client First Name:**	**Client Middle Name:**
Client Address: **Client in Foster Care?** Yes ☐ No ☐ **Client in Group Home?** Yes ☐ No ☐	**Client Phone Number(s):** **(H):** **(C):** **(W):**	**Biological Parent Names/Address/Phone (if different from client and if client is a minor):**
Client DOB:	**Client Soc. Sec.**	**Client Ethnicity:**
County Client lives in:	**Client's Emergency Contact Name:**	**Emergency Contact's phone number:**
MA/PMAP number:	**PMAP** Yes ☐ No ☐	**County Pd:** Yes ☐ No ☐ **# of Co. pd hrs approved:**
Referral Source Name / Address:	**Referral Source Phone Number(s):**	**Referral source Address**

***Describe services needed/requested including home based ARMHS/CTSS Skills Training Psychotherapy, other:**

***** At time of referral, please submit the following current document (if you have them available):**

- Diagnostic Assessment (Most Current)
- County Case Plan
- Crisis Plan
- IEP
- Front page of current CAFAS/CASII or the full Functional Assessment
- Ansel Casey Plan / SELF Plan
- Any other supporting Documents

Referrals and copies of documents can be emailed to referrals@summit-guidance.com, or mailed or faxed to:

Roseville Office
2233 Hamline Ave N, Suite 550
Roseville, MN 55113-5009
(Phone): 651-348-8073
(Fax): 651-348-8968