RTI SERVICE REFERRAL FORM

Please complete the requested PDF form below and email it to referrals@rti-mn.com or fax to 651.455.1385

RTI RESIDENTIALTRANSITIONS

CLIENT INFORMATION

Client Name _____ Gender _____ DOB _____
First MI Last

Residential Address _____
House Number & Street City State 9-Digit Zip County

Phone Number _____ Email _____

Guardian ☐ Y ☐ N If Yes, Guardian Info _____
Name Email or Phone Number

Mental Health Diagnosis _____

REFERRAL INFO

Date of Referral _____ Reason for Referral _____

County of Financial Responsibility _____

CASE MANAGER INFORMATION

Case Manager Name _____ Phone Number _____

Email Address _____

PAYEE INFORMATION

Name _____ Address _____
First Last House Number & Street City State Zip

ADDITIONAL INFORMATION

Spend Down (please check) ☐ Y ☐ N Medical Assistance # _____

Managed Care Organization _____ Insurance ID _____

Medicare ☐ Y ☐ N

☐ **COMMUNITY SERVICES**

- ☐ 24 Hour Emergency Assistance (Tier 4)
- ☐ Individualized Home Supports with Training
  _____ hrs.
- ☐ Housing Stabilization
  Transition ☐ Sustaining ☐

☐ **RESIDENTIAL SERVICES**

If you are submitting a referral for Residential Services, please complete the questions found on page 2

☐ **SUPPORTIVE APARTMENTS PROGRAM**

☐ Dakota County ☐ Ramsey County

☐ **ADULT FOSTER CARE / COMMUNITY RESIDENTIAL SERVICES**

County Preference _____

NOTE: Send completed PDF Referral form to referrals@rti-mn.com. Include any historical client documents please.

Residential Transitions Inc.
Referrals@RTI-MN.com | F: 651.455.1385 | P: 651.457.1461

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PRE-SCREENING QUESTIONS

Required Questions for CRS or Supportive Apartment Services Only

1. **Does the person have an HCBS waiver?**
   ☐Yes ☐No **Waiver type:** _____

2. **Is the person interested in other counties with openings?**
   ☐Yes ☐No
   ***If no**, please indicate if you would like to be placed on our waitlist for a specific county:*
   _____

3. **Is the person open to a roommate?**
   ☐Yes ☐No
   Additional information you'd like us to know:
   _____

4. **Does the person have a source of income?**
   ☐Yes ☐No
   If so, how much per month? _____

5. **Does the person require any accessibility accommodations?**
   ☐Yes ☐No
   If so, please provide additional details:
   _____

6. **Does the person have barriers to success in the referred program that we should be aware of?**
   (could include: physical aggression, verbal aggression, property damage, suicide attempts, frequent hospitalizations, substance use, criminal record, community disturbances, prior evictions, income barriers, etc.)
   ☐Yes ☐No
   If so, please provide the frequency, timeline, and any information that would be helpful in approving an admission with added supports:
   _____

7. **Are there any other 'must-haves' for the person that we should know about?**
   _____

8. **(CRS only) Please indicate level of staff support that the person requires** *(is the person able to be alone? in the community? do they require any 1:1 staffing? do they require awake overnight staff?)*
   _____

COLLATERAL INFORMATION

Please provide the following documents (if applicable)

- MN Choice Assessment
- CSSP/CSP
- LOCUS
- Discharge Summaries
- Neurological/psychological assessments
- Incident reports from the past year
- IEP
- 245D docs (CSSPA, IAPP, SMA, PCP)

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