KAHA CARE LLC - REFERRAL FORM

Phone: 612-458-9096
Email: info@kahacarellc.com

REFERRAL INFORMATION

Referral Date *

Referral Source / Case Manager Name *

Agency / County

Phone

Email

CLIENT INFORMATION

Client Name *

Date of Birth

MA / PMI #

Client Phone

Client Address

Emergency Contact

Relationship

Phone

SERVICES REQUESTED - CHECK ALL THAT APPLY

- ☐ Homemaker Services
- ☐ IHS without Training
- ☐ Respite Care
- ☐ 24-Hour Emergency Assistance
- ☐ Individualized Home Supports (IHS)
- ☐ Night Supervision
- ☐ Companion Services

Other

Services are provided according to agency licensure, authorization, and applicable Minnesota DHS 245D requirements.

SERVICE DETAILS

Requested Start Date

Authorized Hours (if known)

Funding Source - check all that apply

- [ ] CADI
- [ ] DD
- [ ] BI
- [ ] EW
- [ ] Private Pay
- [ ] Other

Other funding source

Primary Diagnosis / Needs (brief)

Mobility / ADL Support Needs

ADDITIONAL INFORMATION

Risk Factors / Safety Concerns

Preferred Language / Communication Needs

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ATTACHMENTS AVAILABLE - CHECK ALL THAT APPLY

- [ ] Service Agreement
- [ ] Support Plan / CSSP
- [ ] Assessment
- [ ] Authorization
- [ ] Other

Other document

SUBMISSION INFORMATION

Name of Person Submitting *

Date *

Certification

- [ ] I certify that the information provided is accurate and that I am authorized to submit this referral.

HOW TO SUBMIT

1. Complete this fillable form and save it to your computer.
2. Email the completed form to info@kahacarellc.com.
3. Use the subject line: New Client Referral - [Client Initials or Name].
4. Kaha Care will review the referral and reach out regarding availability and next steps.

Privacy reminder

This form may contain private or health-related information. Send it only through an email process approved by your organization. Contact Kaha Care if a secure transfer method is needed.