Owakihi, Inc
33 East Wentworth Ave, Suite 280
West St.Paul, MN 55118
Phone: 651-451-2889 / Fax: 651-451-5955

Date of Referral:________________________________ Date Reviewed:________________________________

Name of Individual: _____________________________ MA#: ____

Address: ____

Birthdate: ______________________________________ SSN: ____

Identified Gender:________________________________ Identified Race:_______________________________

Legal Representative: ____

Address: ____

Phone Number: __________________________________ Email:____

Name of Parents (if different than above): ____

Address: ____

Phone Number: __________________________________ Email:____

Diagnosis Code DSM IV TR Name

____________ - _____________ ____

____________ - _____________ ____

Most recent diagnosis date: ____

Referral Form

Reason for Referral and Desired Supports for Success

Why is this individual being referred to Owakihi for services?

What is important to this individual when looking for a service provider?

What do people like and admire about the individual?

How can Owakihi best support the individual in any behavioral issues/concerns they may have?

Does this individual have any legal issues that require consideration (sexual offender history, felony, other)?

What supports does this individual need to be healthy?

What skills does this individual hope to learn or goals would they like to accomplish and how can Owakihi support them?

Is there anything else you would like us to know? Ie. Areas of natural support, where the individual works, where their medical supports are, any history of Evictions, criminal history, credit history

Please complete this page as applicable

Services Requested

☐ Group Home/SLS ☐ ICF/DD ☐ 1:1 In-Home Family Support

☐ Individualized Housing Option ☐ Person Centered Plan ☐ Housing Access Coordination

Roomate/housemate preferred if seeking housing:

☐ Male ☐ Female ☐ Co-ed ☐ Single occupancy

County/ Location Preferred: ____

Staff Support

☐ SILS ☐ Residential 24 hour/awake ☐ Residential 24 hour/asleep

☐ Other supports: ______________________

Requested Service Start Date: _____________________

Referral Source

Name: ______________________________________ Agency:______________________

Address: ____________________________________ Phone: ______________________

____________________________________ FAX: ________________________