



Individualized Home Supports Referral Information

**Contact Information:**

Amanda Olsen - Inquire regarding referral/discharge/program details/program concerns/ program needs

IHS Program Director

218-464-4703 office line 1

218-464-4702 office line 2

218-464-4701 fax

[aolsen@ihsduluth.com](mailto:aolsen@ihsduluth.com)

\* We look for any documentation giving us a clear picture of what the person needs to be supported with. This could include, but is not limited to CSSP A, CSSP, IAPP, SMA, other info as needed.

**Services Provided: Individualized Home Supports with training, Individualized Home Supports remote, 24-hour Emergency Assistance**

These services are licensed under 245D.

**Referral Requests:**

**Please fill in the requested information.**

**Does this person have an active Waiver Yes  No**

**If yes, please identify what type of Waiver and what County: \_\_\_\_\_**

Name	
DOB	
PMI Number	
Current Placement/Contact Information (address and number)	
Social Security Number	

Please give a summary of where the individual is coming from/ why they are seeking this service/ current notes on level of stability (generally any information that is going to help us serve the person to the best of our ability / training for staff) /any information health concerns that are pertinent to the care of the individual, and the outcomes/goals that the individual is seeking assistance and training with. (i.e. household management, budgeting, grocery shopping, attending appointments, meal preparation, etc.)

**Team Members/Contact Information/ Role:**

Role	Name	Email	Phone
Legal Representative (if applicable)			
Mental Health Case Manager (if applicable)			
Rep Payee (if applicable)			
Family Member (if applicable)			

Please email the following to [aolsen@ihsduluth.com](mailto:aolsen@ihsduluth.com)