Recuperative Care Referral Form

Avant Health Recuperative Care Program

Fax: _____ Email: _____ Phone: _____

Date of Referral: ___ / ___ / _____

Client Information

Full Legal Name: _____

Date of Birth: ___ / ___ / _____

MHCP ID (PMI): _____

Phone Number: _____

Current Location (Hospital/Shelter/Other): _____

Current Housing Status: ☐ Homeless ☐ Unhoused ☐ Other: _____

Referring Clinic or Hospital Information

Facility Name: _____

Clinic or Hospital Contact Person: _____

Phone: _____

Fax: _____

Email (optional): _____

Medical Eligibility for Recuperative Care

Please confirm that the individual meets the following all required criteria for Recuperative Care services:

☐ The individual is 21 years or older (if Medical Assistance) or 19 years or older (if MinnesotaCare).
☐ The individual is experiencing homelessness or is unhoused.
☐ The individual has a short-term medical condition that requires support or monitoring but does not require hospitalization.

☐ The individual can independently complete activities of daily living, including using the bathroom and transferring.
☐ The individual's behavioral health needs do not exceed what can be supported in a community-based setting.
☐ The individual would benefit from supportive services such as:

☐ Basic nursing care ☐ Wound care ☐ Medication support
☐ Care coordination ☐ Patient education ☐ Discharge planning

Medical Information & Diagnosis

Primary Medical Condition Requiring Recuperative Care:

_____

ICD-10 Code (Required): _____

Expected Duration of Recuperative Care Need (days): _____ (max 60 days)

Discharge Plan or Anticipated Follow-Up:

_____

Provider Attestation

I attest that the above-named individual is medically appropriate for community-based Recuperative Care services at Avant Health and meets MHCP criteria for eligibility.

Referring Provider Name: _____

Signature: _____ Date: ___ / ___ / _____

Please fax or email this completed form to Avant Health.
Thank you for your referral.