



REFERRAL FOR SERVICES

7900 Excelsior Blvd., Ste 200 • Hopkins, MN 55343
Phone: 952.658.8995 • Fax: 952.777.2263

Date: _____

Participant Information

Participant Name: _____	DOB: _____
Street Address: _____	Phone: _____
City: _____	Language: _____
State: _____ Zip Code: _____	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other

Health Information

Dx: _____
Dx: _____

Insurance Information

PMI: _____	Insurance: _____
Waiver: _____	Insurance ID: _____

Participant's Representative ("PR") Information

Does the participant have an Authorized Representative? ☐ Yes ☐ No If yes, please provide the following information:

PR Name: _____	Relationship: _____
Email: _____	Phone: _____

Services Requested

CFSS Consultation Services	# of Sessions
<input type="checkbox"/> CFSS Consultation	_____ year
In-Home Services	Hours Auth
<input type="checkbox"/> PCA (Traditional)	_____ day
<input type="checkbox"/> CFSS (Agency Model)	_____ day
<input type="checkbox"/> HMK	_____ week
<input type="checkbox"/> Chore Services (please specify)	_____ week
Transportation	Hours Auth
<input type="checkbox"/> Medical Transportation (NEMT)	_____
<input type="checkbox"/> Waiver Transportation	_____ week

245D Services	Hours Auth
<input type="checkbox"/> ICLS	_____ week
<input type="checkbox"/> IHS with Training	_____ week
<input type="checkbox"/> IHS without Training	_____ week
<input type="checkbox"/> IHS with Family Training	_____ week
<input type="checkbox"/> Respite	_____ week
<input type="checkbox"/> Night Supervision	_____ week
<input type="checkbox"/> Companion	_____ week

Referral Source Information

Name: _____	Phone: _____
Email: _____	Fax: _____
Agency Name: _____	Agency Phone: _____
How did you hear about us? _____	

Additional Information

Client lives alone?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, please list: _____
Pets in the Household?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list: _____
Current smoker?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Does anyone else in the household smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No
Hx of SPMI?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hx of violence? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is client a registered sex offender?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Guns at Home? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Free Parking? <input type="checkbox"/> Yes <input type="checkbox"/> No



Comments/Notes

Please provide any clarifications or additional information you believe would be pertinent. If you are referring for in-home or 245D services, please specify the caregivers' preferences—such as gender, preferred shift (morning, afternoon, or evening), and any other relevant details.