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

REFERRAL FOR SERVICES

Reset

Date: _____

Participant Information

Participant Name: _____ DOB: _____
Street Address: _____ Phone: _____
City: _____ Language: _____
State: _____ Zip Code: _____ Gender: ☐ M ☐ F ☐ 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 Services	# of Sessions	
☐ CFSS Consultation		year
In-Home Services	**Hours Auth**	
☐ PCA/CFSS Agency Model		day
☐ HMK		week
☐ Chore Services (please specify)		week
Housing Stabilization	**Units Auth**	
☐ Consultation		year
☐ Transition ☐ Sustaining		year
Transportation	**Hours Auth**	
☐ Medical Transportation (NEMT)		
☐ Waiver Transportation		week

245D Services	Hours Auth	
☐ ICLS		week
☐ IHS with Training		week
☐ IHS without Training		week
☐ IHS with Family Training		week
☐ Respite		week
☐ Night Supervision		week
☐ Companion		week
Alzheimer's/Dementia program designed for Caregivers speaking Russian, Ukrainian, and Uzbek		
☐ Support Group for caregivers		
☐ Free Respite Care	4 hrs	week

Referral Source Information

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

Additional Information

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

Comments/Notes

Please provide any clarifications or additional information that you believe would be pertinent. If you are referring for in-home or 245D services, please specify the caregivers' preferences, as well as the preferred dates and times.