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

REFERRAL FOR SERVICES

Intake 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: ______________

Authorized Representative ("AR") Information

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

AR Name: ______________ Relationship: ______________
Street Address: ______________ Phone: ______________
City: ______________ Alt. Phone: ______________
State: ______ Zip Code: ______________ Email: ______________

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		year
☐ Sustaining		year

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
Transportation	**Hours Auth**	
☐ Medical Transportation (NEMT)		
☐ Community Transportation		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.