Minnesota DHS – Home & Community Services Referral Form

(For PCA, CFSS, and other HCBS Programs)

Provided by: Hold My Hand Inc
408 Cedar Ave S, Ste 5, Minneapolis, MN 55454
Email: info@hmyhand.com
Tel: 952-688-1962 Fax: 1-888-651-7390

1. Participant Information
Last Name: _____ First Name: _____ Middle: _____
Date of Birth (MM/DD/YYYY): ____ / ____ / _____
Gender: ■ Male ■ Female ■ Other ■ Decline to Answer
PMI # (if known): _____
Primary Language: _____
Interpreter Needed? ■ Yes ■ No
Current Address: _____
City: _____ State: MN ZIP: _____
Phone: _____ Email: _____

2. Responsible Party / Participant Representative (if applicable)
Name: _____
Relationship to Participant: _____
Address: _____
Phone: _____ Email: _____

3. Current Services (Check all that apply)

- ■ PCA Services
- ■ CFSS – Agency Model
- ■ CFSS – Budget Model
- ■ Other HCBS (specify): _____
- ■ Waiver Services (specify): _____
- ■ Other State Plan Services: _____

4. Referral Type (Check one or more)

- ■ New Service Request
- ■ Service Reassessment
- ■ Change in Service Model (PCA → CFSS, Agency → Budget)
- ■ Additional Service Type Request
- ■ Other: _____

5. Medical / Functional Summary (brief overview or attach documentation)
_____
_____

6. Signatures

Participant / Responsible Party:
Signature: _____ Date: ____ / ____ / _____

Referral Source:
Name: _____
Agency/Organization: _____
Phone: _____ Email: _____
Signature: _____ Date: ____ / ____ / _____

Submit completed form to:

Hold My Hand Inc, 408 Cedar Ave S, Ste 5, Minneapolis, MN 55454
Email: info@hmyhand.com Tel: 952-688-1962 Fax: 1-888-651-7390