CFSS Consultation Services Referral Form

Thank you for your interest in Lifeworks. To start your referral for CFSS Consultation Services, please fill out the entirety of this form. The highlighted and * fields are required. When finished, email the form to lifeworksreferrals@lifeworks.org.

Please ensure the applicable sections are complete to avoid delays.

Services Screening:

How did you hear about Lifeworks?	Select:
Is the client transferring from another provider?	Select:
Is the client a former Lifeworks client?	Select:
Is the client receiving or has received CFSS, CDCS, PCA or CSG services?	Select:

Consultation Overview

CFSS Consultation- Provides guidance and support in writing the CFSS Service Delivery Plan (SDP) based on the clients' assessed needs. CFSS Consultation helps people make clear and smart choices. It supports clients in picking what is best for their needs and makes sure they understand their rights, duties, and options.

- Lifeworks cannot act as both the consultation and service delivery provider.
- Consultation must be completed before receiving the service delivery portion of CFSS with another agency.

1. Budget Model- In this model, the client and their supports have more control. With help from a Financial Management Services (FMS) provider, you can hire your own workers, manage your budget, and make decisions about your services. The FMS teaches you how to be an employer, helps with required employment paperwork, and bills DHS.

2. Agency Model- In this model, the agency is the legal employer of your workers. They handle hiring, training, supervising, scheduling, evaluating, payroll, billing, and ensuring workers follow all program rules. You still get to share your preferences about which workers you want.

*the model that is selected on the referral form, can be changed after you have been educated on the different models available.

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The highlighted and * portions MUST be completed to avoid delays in the process. Please fill in as much information as you are able.

1. **Client Information-** This is the individual that is receiving services.

Preferred Start Date			
Legal First Name*			
Legal Middle Name			
Legal Last Name*			
Gender	Select:		
Preferred Name if Different			
Address*- include city, state and zip			
Is this client a safe at home (SAH) participant? SAH is a Minnesota address confidentiality program	☐	No	☐ Yes
PMI Number*			
Guardianship Status*	Select:		
Date of Birth*			
Ethnicity	Select:		
Client Phone Number* (required if client is own legal guardian)			
Client Email Address* (required if client is own legal guardian)			
Preferred Language			
Would you like an interpreter?	Select:		
Consultation Model* Please review the section above for more information on the models available.	☐	Budget Model	
	☐	Agency Model	
	☐	Unknown/ Undecided	
Pronouns	Select:		
County of Residence*			
County of Financial Responsibility*			
Waiver Type	Select:		
If the client is transferring from another provider, please provide the name of the provider you are transferring from.			

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2. **Responsible Party-** Considered the main point of contact for the client. They are responsible for attending meetings and signing documentation.
   Please note, the responsible party can be updated during the intake meeting if necessary. If the client is their own guardian, they can be their own responsible party.
   - You will be asked for your date of birth, this is needed to verify your identity for electronic signatures in MyHealthPointe. MyHealthPointe is a portal to view and electronically sign service-related documents.
   - This role is also referred to as the "participant representative".

Legal First Name*	
Legal Last Name*	
Gender	Select:
Pronouns	Select:
Date of Birth*	
Email Address*	
Phone Number*	
Address*- include city, state and zip	
Preferred Language	
Relationship to Client*	Select:

3. **Guardian** (If applicable and different than the Responsible Party)- A parent or legal representative authorized to act on behalf of the client.
   - You will be asked for your date of birth, this is needed to verify your identity for electronic signatures in MyHealthPointe. MyHealthPointe is a portal to view and electronically sign service-related documents.

Legal First Name*	
Legal Last Name*	
Gender	Select:
Pronouns	Select:
Date of Birth*	
Email Address*	
Phone Number*	
Address- include city, state and zip	
Preferred Language	
Relationship to Client*	Select:

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4. **Primary Emergency Contact-** A person a client chooses to contact if there's an emergency or if the client cannot communicate what they need.

First Name	
Last Name	
Gender	Select:
Pronouns	Select:
Email Address	
Phone Number	
Address- include city, state and zip	
Preferred Language	
Relationship to Client	Select:

5. **Case Manager/ Contact at County-** This role is the point of contact through your county for authorization of services.

Company	
First Name	
Last Name	
Gender	Select:
Pronouns	Select:
Email Address	
Phone Number	
Address- include city, state and zip	

6. **MN Choices Assessor** (only needed if there isn't a case manager or contact at the county)- This is the person from the county who completed the in-person assessment. They review your needs, goals and preferences to determine your eligibility and authorized amount of support.

Company	
First Name	
Last Name	
Gender	Select:
Pronouns	Select:
Email Address	
Phone Number	
Address- include city, state and zip	

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7. **Care Coordinator** (Managed Care Organization)- Point of contact through the insurance company for clients on managed care plans. Typically for individuals over age 65 on state health plans.

Company	
First Name	
Last Name	
Gender	Select:
Pronouns	Select:
Email Address	
Phone Number	
Address- include city, state and zip	

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