

Marsin Home Care Referral Form

Fax to 952-977-9152 | Questions: 888-439-5801 | We respond within 1 business day.

Referring for

Service*

- ☐ CFSS Consultation
- ☐ CFSS Services
- ☐ 245D Basic Supports

About you

Your name*

Your role*

Agency or county

Phone*

Email*

About the participant

First name*

Last name*

Date of birth (if available)

PMI or MA number (if available)

County of residence*

Participant phone

Preferred language*

☐ An interpreter is needed

Legal representative name (if any)

Legal representative phone

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CFSS Consultation referrals only

Does this person currently get CFSS (formerly PCA) or waiver services from Marsin Home Care?*

Answer*

☐

No

☐

Yes

☐

Not sure

If Yes, Marsin cannot be the consultant. Send the form anyway and we will call to help.

MnCHOICES assessment date (if known)

Service model interest

☐

Agency model

☐

Budget model

☐

Not sure yet

CFSS Services and 245D Basic Supports referrals only

What support is the participant looking for?

Send the referral

☐

I have permission to share this information.*