CARECONNECTION MN
CONNECTING YOU TO CARE

HSS Consultation Referral Form
Email completed form to:
dennis@careconnectionminnesota.com

Client Information

Client Name (as it appears in MN-ITS)

First Name | Middle Name | Last Name

DOB

Month | Day | Year

PMI

Renewal Date

Month | Day | Year

Phone Number

Area Code | Phone Number

Consultation Type

- ☐ Initial
- ☐ Renewal

Referring Provider/Agency Information

Referring Provider/Agency Name

Contact Name

First Name | Last Name

Email

example@example.com

Phone Number

Area Code | Phone Number

NPI/UMPI

Referring entity attests that the client is over 18, homeless/ at risk of homelessness/ transitioning from facility and has authorized release of information to CCM.

- ◯ YES
- ◯ NO

Additional Documentation Attached?

Please Select