Atlas Community Care
WHERE COMPASSION MEETS CAPABILITY.

Client Referral Form

Michigan

Michigan Home Help Program (MDHHS)

Serving Michigan · routed through the client's local county MDHHS office

SEND TO ATLAS: Fax (406) 795-5656 · Phone (989) 220-1867 · 3200 Greenfield Rd, Ste 261, Dearborn, MI 48120

We reply within 1 business day. This form is fillable on-screen or by hand — please print clearly and fax.

Does the client have ACTIVE Medicaid? (Medicare alone does not qualify) ☐ Yes ☐ No ☐ Unsure

1. REFERRAL SOURCE

Name | Title / role | Date

Organization / agency | Phone

Email

Preferred contact method

☐ Prefer phone ☐ Prefer email ☐ Prefer text

Best time to reach

☐ Please have an Atlas team member call me back about this referral

2. CLIENT INFORMATION

Client full name | Date of birth | Medicaid ID #

Home address | Phone

City | ZIP | County

Guardian / POA (if any) | Guardian phone

Primary language | Physician | Physician phone

Is the client currently in a hospital or facility? ☐ Yes ☐ No If yes, expected discharge date:

3. CARE NEEDS

Primary diagnosis / reason for care

Help needed with (check all that apply):

☐ Bathing ☐ Dressing ☐ Toileting ☐ Transfers / mobility
☐ Eating ☐ Meal prep ☐ Housekeeping / laundry ☐ Medication reminders
☐ Shopping / errands ☐ Grooming ☐ Exercise / ROM ☐ Other

Current services (if any):

☐ MI Choice Waiver ☐ Community Living Supports ☐ Home health ☐ None / Other

Brief summary of the client's situation

(continued)

4. CAREGIVER

Choose one:

☐ Client HAS a family member or friend who wants to be the paid caregiver

☐ Client NEEDS Atlas to assign a caregiver

Caregiver name (if known) | Relationship | Phone

Is that caregiver a spouse, the parent of a minor child, under age 18, or the fiscal intermediary? ☐ Yes ☐ No

Note: Intake referral only. Atlas carries it into the MDHHS Home Help process (DHS-390 + MDHHS-6200); the participant chooses their caregiver.

5. CONSENT & HIPAA AUTHORIZATION

By signing, I authorize release of the client's information on this form to Atlas Community Care to determine eligibility and coordinate care, and I authorize Atlas, the client's providers, and MDHHS Adult Services worker to use and disclose the client's protected health information (PHI) to process this referral and enroll the client, as permitted under HIPAA (45 CFR 164). I am the client, the client's authorized representative, or a provider authorized to make this referral. This authorization may be revoked in writing at any time.

Referrer signature | Date