Atlas Community Care
WHERE COMPASSION MEETS CAPABILITY.

Client Referral Form

Montana

Montana Community First Choice (CFC) / Personal Assistance Services (PAS)

Serving Yellowstone, Missoula, Flathead & Gallatin counties

SEND TO ATLAS: Fax (406) 795-5656 · Phone (406) 272-2535 · 208 N 29th St, Ste 230, Billings, MT 59101

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

Service-area county

☐ Yellowstone ☐ Missoula ☐ Flathead ☐ Gallatin ☐ Other (write above)

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):

☐ Big Sky Waiver ☐ Home health ☐ Hospice ☐ 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 or the parent of a minor child they care for? ☐ Yes ☐ No

Note: Montana CFC/PAS lets the client choose their own caregiver. Atlas hires and pays the chosen caregiver and provides a trained backup.

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 Mountain-Pacific Quality Health (MPQH) 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