QUALIFIED SERVICE PROVIDER (QSP) REFERRAL/REQUEST

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADULT AND AGING SERVICES
SFN 1268 (4-2025)

Clear Fields

When are services needed?	Individual Name	Date of Birth	Age

Gender
☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Nonbinary

Address	City	State	ZIP Code

County	Telephone Number	Lives Alone
		☐ Yes ☐ No-Specify Relationship:

Describe any notable health or behavior concerns **(NO DIAGNOSIS)**

Time of Day Services are Needed	Type of QSP Individual Wants
☐ Day ☐ Evening/Night ☐ Both	☐ Individual QSP ☐ Agency QSP ☐ No Preference/Either

Payment Source	**Recipient Liability (RL) or SPED Fee**	Rural Differential (RD)/Tier
☐ Medicaid ☐ Medicaid Pending ☐ N/A		

Explanation of Services: Specific Tasks/Units Authorized/Frequency

Informal Supports/Emergency Contact(s) (first and last name along with phone number)

Concerns in the Home (i.e., smoking, pets. environmental, etc.)

Additional Information Important for this Referral (i.e., Is there any assistance with devices and/or equipment)

QSPs Used (if any) - (put this in the body of the email going to QSP Navigators)	QSP Navigator Initials

Case Manager (First and Last Name)	Email Address	Telephone Number