Volunteers of America MINNESOTA

Community Family Supports
7625 Metro Boulevard
Edina, MN 55349
PH: 952-945-4000
FAX: 888-526-2781

1030 4th Street SE
St. Cloud, MN 56304
PH: 320-251-2326
FAX: 888-526-2781

Case Management Referral/Intake Form

Program: ☐ Adult CM ☐ Child CM

Client's Name: _____ Nickname(s): _____
(Last, First)

Date of Birth: _____ Gender: ☐ M ☐ F Race/Cultural Heritage: _____

Address: _____ City: _____ State: MN Zip: _____

Home Phone: _____ Work Phone: _____ Other Phone: _____

County of Residence/Responsible County: _____

*Referred by/Agency Name: _____ Phone: _____

Family Information

(Child) Name of Parent: _____ Phone: _____ Address: _____

(Child) Name of Parent: _____ Phone: _____ Address: _____

(Adult) Name of Relative or Significant Person: _____

Relation to Client: _____ Phone: _____

Insurance Information:

Insurance Company: _____ Policy #: _____

Authorization #: _____ Authorization Dates: _____ Group #: _____

Referral Information:

Reason for Referral: _____

Presenting Problems/Diagnosis: _____

Currently Receiving CM Services? ☐ Yes ☐ No Eligibility Screen Needed? ☐ Yes ☐ No

Case Manager Name: _____ Phone: _____

Therapist: _____ Clinic: _____ Phone: _____

How Often: _____ Transportation Needed? ☐ Yes ☐ No

Psychiatrist: _____ Clinic: _____ Phone: _____

Medications: _____

Physician: _____ Clinic: _____ Phone: _____

Medical Concerns: _____

Other Services/Providers: _____

Date of Intake: _____ Staff Completing Form: _____

☐ Staff completing intake requested diagnostic assessment

*** If the referring agency is completing this form, attach a copy of the most recent diagnostic assessment and fax to 888-526-7281.**