

Case Management Referral/Intake Form

Program: Adult CM Child CM

Client's Name: _____		Nickname(s): _____	
<i>(Last, First)</i>			
Date of Birth: _____	Gender: _____	Race/Cultural Heritage: _____	
Address: _____	City: _____	State: <u>MN</u>	Zip: _____
Home Phone: _____	Work Phone: _____	Other Phone: _____	
County of Residence/Responsible County: _____			
*Referred by/Agency Name: _____		Phone: _____	
<u>Family Information</u>			
(Child) Name of Parent: _____	Phone: _____	Address: _____	
(Child) Name of Parent: _____	Phone: _____	Address: _____	
(Adult) Name of Relative or Significant Person: _____			
Relation to Client: _____		Phone: _____	
<u>Insurance Information:</u>			
<input type="checkbox"/> Medical Assistance	<input type="checkbox"/> PMAP-MA: _____	Policy #: _____	Group # _____
<input type="checkbox"/> Private Insurance: _____		Policy #: _____	Group # _____
<u>Referral Information:</u>			
Reason for Referral/ _____			
Presenting Problems: _____			
Diagnosis: _____			
Other Information: _____			
Currently Receiving CM Services? <input type="checkbox"/> Yes <input type="checkbox"/> No		Past CM Services? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Therapist: _____	Clinic: _____	Phone: _____	
Psychiatrist: _____	Clinic: _____	Phone: _____	
Medical Concerns: _____			
Other Services/Providers: _____			
Date of Intake: _____		Staff Completing Form: _____	
<input type="checkbox"/> Diagnostic Assessment & Verification Form requested (required).		Date and agency of last DA: _____	
*If the referring agency is completing this form, please attach a copy of the most recent diagnostic assessment and fax to 888-526-2781.			