Date:

Adult, Child & Family Services, LLC

ARMHS Referral Form

REFERRAL SOURCE (AGENCY/PERSON):____

Phone: ______________ Fax: _____________ Email Address:______________________________

Clients Name: _____________________ DOB: ________________ GENDER: __________

Phone Number:_____________________ SOC. SEC. # ____________________________

Address: ____

Parent/Guardian/ Spouse Name: ______________________________

If Guardian, Explain Relationship:______________________________

Phone Number:________________________

Case Manager ? Yes____ No____

Name:____________________________ Email address:____________________________

PLEASE ATTACH THE MOST RECENT DIAGNOSTIC ASSESSMENT WITH THIS FORM

If there is no current DA, does ACFS need to complete one? _____________

	Total Admissions	Most recent admission
State Hospital	__________________	____________________
Inpatient Hospital	__________________	____________________
Treatment Center	__________________	____________________

Areas of need (check all that apply)

- ☐ Community intervention
- ☐ independent living skills
- ☐ home maintenance
- ☐ educational functioning
- ☐ Medication Monitoring
- ☐ symptoms management
- ☐ vocational functioning
- ☐ medical/ dental needs
- ☐ Benefits assistance
- ☐ self-care
- ☐ social functioning
- ☐ other _______________

BRIEF DESCRIPTION OF PROBLEM (attach separate sheet if necessary. please forward medical & behavioral information, court reports, social summaries, previous DA's, etc.)

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Does client know of this referral? _____ Release of information completed? _______

Billing Information (MUST be MA or have a PMAP to qualify for services)

primary Insurance _______________ Policy/ PMI # _________________ Group # ______________

Please fax this completed form to 507.344.1726 or email to kcooper@acfsmankato.org