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Date of Referral:

Adult Mental Health Case Management Referral Form

Client Name:	Date of Birth:
Address:	
County of Residence: *Please note – clients must be residents of Hennepin or Ramsey County*	
Phone number:	

Referral Source:	Relationship to Client:
Agency/Clinic/Organization:	
Address:	
Phone number:	Fax Number:

Insurance Company:
Primary Policy Holder:
Group Number:
Policy/ ID Number:

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Reason for referral and description of how case management services can help this client develop better mental health:
What services (mental health, educational, healthcare, etc.) are already in place, including provider(s)?
Additional information to support this referral (engagement tips, key support people, significant history, etc.):

☐ **Release of information included?**

**Please note that external referrals will not be accepted without a release of information.

☐ **SPMI Status Documented in DA** ☐ **SPMI Status Documented Below**

For external referrals, please send referral form, release(s) of information, and Diagnostic Assessment (if possible) to:

mhintake@clues.org (preferred – please remember to encrypt your message)

or Fax: (612) 871-1058, Attn: MH Intake
SPMI Documentation to accompany Diagnostic Assessment:

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Diagnostic Assessment was completed by _____ (provider)

on _____ (date) for _____ (client).

This client meets eligibility criteria for a Serious and Persistent Mental Illness (SPMI). Serious and Persistent Mental Illness means the condition of an adult who has a mental health diagnosis AND meets at least one of the following criteria (check all that apply):

- ☐ The individual had two or more episodes of inpatient care for mental illness within the past 24 months; OR
- ☐ The member had continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the past 12 months; OR
- ☐ The member has been treated by a crisis team two or more times within the past 24 months
- ☐ The individual has a diagnosis of schizophrenia, bipolar disorder, major depression or borderline personality disorder; evidences a significant impairment in functioning; and has a written opinion from a mental health professional stating he or she is likely to have future episodes requiring inpatient or residential treatment unless community support program services are provided
- ☐ The individual has, in the last three years, been committed by a court as a mentally ill person under Minnesota statutes, or the adult's commitment as a mentally ill person has been stayed or continued
- ☐ The individual was eligible under one of the above criteria, but the specified time period has expired
- ☐ The individual was eligible as a child with severe emotional disturbance, and the member has a written opinion from a mental health professional, in the last three years, stating that he or she is reasonably likely to have future episodes requiring inpatient or residential treatment of a frequency described in the above criteria, unless ongoing case management or community support services are provided

_____ _____

Provider Signature (with credentials) Date

_____ _____

Supervisor Signature (unlicensed staff only) Date