Adult Rehabilitative Mental Health Services (ARMHS)

****Our ARMHS department does not provide transportation services, housekeeping services, PCA/ADL support services, case management, or medication administration/education services****

****At this time, ILP is only contracted to provide ARMHS in the following counties: Hennepin, Ramsey & Washington County****

Referral Date: _____

Personal Information:

Full Legal Name:_____ Date of Birth: _____

Gender/Preferred Pronouns:_____ Phone Number: _____

Address: _____ Email Address: _____

City, State, Zip: _____ County of Residence: _____

SSN: _____ PMI Number: _____

Economic Assistance Case Number:_____ PMAP/PPHP (If so, which one): _____

Preferred Language: _____ Interpreter Needed (Y/N): _____

Primary Diagnosis: _____

Emergency Contact Information:

Name: _____ Relationship to Client: _____

Address: _____ Phone Number: _____

City, State, Zip:_____ Email Address: _____

Preferred Language: _____ Interpreter Needed (Y/N): _____

Legal Status & Legal Representative Contact Information:

☐Responsible for Self

☐Guardian/Power of Attorney/Health Care Directive Agent (Complete Section Below)

Name: _____ Relationship to Client: _____

Address: _____ Phone Number: _____

City, State, Zip: _____ Email Address: _____

Preferred Language: _____ Interpreter Needed (Y/N): _____

Case Manager/Care Coordinator Contact Information:

Name: _____ Title: _____

Agency: _____ Phone Number: _____

Fax Number: _____ Email Address: _____

Other Provider Contact Information (Psychiatrist, Psychologist, Therapist, Mental Health CM, etc.):

Name: _____ Title: _____

Agency: _____ Phone Number: _____

Fax Number: _____ Email Address: _____

Name: _____ Title: _____

Agency: _____ Phone Number: _____

Fax Number: _____ Email Address: _____

Financial Worker Contact Information:

Financial Worker Name: _____ Phone Number: _____

County of Financial Responsibility: _____ Fax Number: _____

Email Address: _____

Insurance Information:

☐Medical Assistance ☐Medica ☐UCare ☐HealthPartners

☐Blue Cross ☐ Hennepin Health ☐ United Health ☐ Other: _____

Insurance Policy: _____ Effective Date: _____

Reasons for Referral:

Primary Concerns/Needs for Services: _____

_____

Safety Concerns: _____

_____

Has this Individual Received ARMHS before? If so, when did services end, and why?

Requested Documentation to Submit with Referral (If Applicable):

- ☐ Existing Diagnostic Assessment (DA)/Functional Assessment (FA)/Individual Treatment Plan (ITP)
- ☐ Community Support Plan (CSP)
- ☐ Coordinated Services and Supports Plan (CSSP)
- ☐ Relevant History

***Please Submit Referral Form & Request Documentation to: ARMHSReferrals@ilpmn.com**