Hennepin County Targeted Case Management (TCM) Referral Form

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Please send referral form along with requested supporting documentation to our Central Access Team:

Fax: 651-677-5714 *Email: centralaccess@radiashealth.org* *Phone: 612-453-4010*

Date of Referral	
Name of Referred Individual	
Phone Number	
Date of Birth	
Social Security Number	
Race	
Race: **☐African American/Black** **☐Asian** **☐Caucasian /White** **☐Indian (American)/Alaska** **☐Native Hawaiian/Pacific I** **☐Unknown** **☐Some Other Race Alone** **☐Specify Other Race** _____	
Ethnicity	
Gender	
Pronouns	
Primary Language / Interpreter Needs	
Home Address	
Current Location (if other than home)	
Case Manager Assignment Consideration (gender, culture, etc)	

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Insurance Information

Insurance Type *Individuals typically need to be open with Medicaid (straight MA or PMAP) to be enrolled.*	☐ Straight MA (Medicaid) ☐ PMAP ☐ Medicare ☐ Private/Other: _____
PMI	
Health Plan (if applicable)	
Other Insurance Information	

Qualifying Diagnosis

A qualifying diagnosis is needed to be eligible for TCM services. Check all that apply:

☐ Schizophrenia

☐ Schizoaffective Disorder

☐ Bipolar Disorder

☐Major Depression

☐ Borderline Personality Disorder

☐ Other (specify): _____

Service Related Qualifications

☐ Reoccurring significant symptoms of their mental illness, and insufficient strengths and resources that result in psychiatric hospitalizations, residential treatment and/or interventions due to psychiatric crises.

☐ Diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder; and significant impairment of functioning due to the mental illness that could result in inpatient or residential treatment.

☐ Been committed (or commitment stayed or continued) in the last three years by a court as a person who is mentally ill under Chapter 253B. Civil Commitment.

☐ Initial eligibility under the above reasons and in the opinion of a mental health professional, and continues to need MH-TCM services to reduce hospitalization and/or residential treatment.

☐ A child just reaching adulthood who is currently receiving children's MH-TCM; and in the opinion of a mental health professional, continues to need MH-TCM services to reduce hospitalization and/or residential treatment.

☐ The adult has had two or more usages of Crisis Response Services

Functional Qualifications (check all that apply)

☐ Diagnosis of qualifying SPMI that significantly impairs functioning

☐ Accessing mental health services

☐ Substance use

☐ Vocational or educational functioning

☐ Social / interpersonal functioning

☐ Self-care and independent living abilities

☐ Managing medical or dental health

☐ Ability to obtain or maintain benefits

☐ Ability to obtain or maintain housing

☐ Ability to use transportation

☐ Legal involvement

☐ Under commitment (check all that apply):

- ☐ Hennepin Co CFR/commitment – requesting a transfer of agency

☐ Hennepin Co CFR/commitment – transition from ACT to TCM

☐ 2+ hospitalizations for MI in the last 24 months

☐ Continuous psychiatric placement or residential treatment for 6 months during the last 12 months

Hospitals / Facility Information

Facility / Hospital	Dates

Additional Documentation to Attach

☐ DA within 180 days (copy attached or on file) *(If needed, schedule for CA completion.)*

☐Statement of Need (copy attached or on file)

☐Hospital Records

☐ Previous Pre-petition screening reports and Commitment Court Orders

☐ Hospital Records

☐ Other supporting documents attached: _____

Additional Notes:

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Referring Party

Referring Party Name / Agency	
Email	
Phone	