Minnesota CarePartner

New Client Referral

Phone 612.289.5656
Fax 651.925.0278
www.mncarepartner.com
info@mncarepartner.com

COVID-19 Service Notice

COVID-19 has required that we move most of our services to the Zoom teletherapy platform. All that is required to take advantage of this is a smart device with internet access and a camera. Please indicate the client's ability to utilize teletherapy services below.

- ☐ Client has the technology, internet access and support to access teletherapy services
- ☐ Client has access to internet but may need assistance with getting a device to access teletherapy services.
- ☐ Client does not have consistent access to internet or technology to access teletherapy services.
- ☐ Unknown

Clear Form

Client Information

Client First Name: Middle: Last:

Gender: ☐ Female ☐ Male ☐ Trans ☐ Genderqueer/Non-Binary ☐ Other: ☐ Prefer not to Disclose

Race/Ethnicity: ☐ African-American ☐ Asian/Asian-American ☐ Native-American ☐ Latinx ☐ East-African ☐ West-African ☐ Caucasian ☐ Multiracial/Other: ☐ Prefer not to say

Date of Birth: Social Security # Phone #

Best time to call: ☐ Morning ☐ Afternoon ☐ Evening Is it safe to leave a message? ☐ Yes ☐ No

eMail: Preferred method of communication: ☐ Calls ☐ Texts ☐ eMails

Current Address:

Address Type: ☐ Client's ☐ Parent/Guardian ☐ Foster home ☐ Shelter ☐ Group home ☐ Other:

Who has custody of the client? ☐ Parents ☐ County ☐ Other:

Name of Parent(s)/Legal Guardian: Phone:

Foster Parent(s) (if applicable) Phone:

If Client is a minor, Who should the provider schedule with?

Primary Insurance: ☐ UCare ☐ Medica ☐ Medical Assistance ☐ HealthPartners ☐ BlueCross ☐ Cigna ☐ Other: _____ Is this policy: ☐ Medicaid ☐ Commercial

Commercial Plan ID # Group #

Medicaid Plan PMI #: Group #

Referral Information

Referent Name: Agency:

Phone Number: eMail:

Is there an ROI attached to allow us to update you? ☐ Yes ☐ No How did you hear about us?

Is a current/recent Diagnostic Assessment available? ☐ Yes ☐ No

Service Needs & Primary Concerns

Services Requested: *Check all that apply*

☐ Diagnostic Assessment ☐ DC 0-5 – Infant/Child DA ☐ Individual ARMHS-Skills ☐ Individual CTSS-Skills

☐ Individual Therapy ☐ TeleTherapy (Zoom) ☐ Family Therapy ☐ Nutrition/Dietitian Services ☐ Goodwill/FAST-X

☐ Minneapolis Jeremiah Program ☐ Hennepin CTSS Skills Pods ☐ Ramsey CTSS Skills Pods

☐ Ramsey County Community Support Program (Adults with Children Only) *Choose services below*

☐ Nutrition Services ☐ In-Home Parenting Coach ☐ BIPOC Breastfeeding Support ☐ Trauma-Informed Yoga ☐ BIPOC Doula

☐ Hennepin County Community Support Program (Adults with Children Only) *Choose services below*

☐ Nutrition Services ☐ In-Home Parenting Coach ☐ BIPOC Breastfeeding Support ☐ Trauma-Informed Yoga ☐ BIPOC Doula

☐ Other Services Not Listed Above: *please describe:*

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Primary Concerns: *Check all that apply*

☐ Depression ☐ Anxiety ☐ Post-Traumatic Stress Disorder ☐ Psychosis ☐ Autism Spectrum Disorder ☐ Aggression
☐ Behavioral Concerns-Home ☐ Behavioral Concerns-Work ☐ Behavioral Concerns-Other ☐ Suicidal Ideation
☐ Homicidal Ideation ☐ History of Suicide Attempts ☐ Self-Injurious Behavior ☐ Recent Life Transition/Adjustments
☐ Parenting Challenges ☐ Anger Management ☐ Emotional Regulation ☐ Child Abuse-Survivor ☐ Child Abuse-Perpetrator
☐ Intimate Partner Violence-Survivor ☐ Intimate Partner Violence-Perpetrator ☐ Intimate Partner Violence-Child Witness
☐ History of Sexual Assault/Abuse ☐ Emotion Regulation/Coping ☐ Learning/School Skills Concerns ☐ COVID Challenges

☐ Other Concerns: *please describe:*

Service Preferences:

Do you have a preference for a specific MNCP therapist? ☐ No ☐ Yes If yes, whom?

Any cultural or gender preference? ☐ No ☐ Yes If yes, please describe:

Is an interpreter needed? ☐ No ☐ Yes If yes, please describe:

Any other cultural/language considerations? ☐ No ☐ Yes If yes, please describe:

Client availability for services:
☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday
☐ Mornings ☐ Afternoons ☐ Evenings Scheduling Notes:

Safety Concerns & Child Protection Involvement

If Child Protection Involvement, please provide harm statement and collateral info:

Client risk of harm to self: ☐ Low ☐ Medium ☐ High ☐ Crisis To others: ☐ Low ☐ Medium ☐ High ☐ Crisis

Is there violence in the home? ☐ Yes ☐ No Describe:

Active Orders?: ☐ OFP ☐ DANCO ☐ HRO ☐ None If yes, who is involved?

Please describe any other safety concerns we should be aware of:

Additional Information & File Uploads

Please provide any additional information you think we should have to facilitate this referral:

File Uploads: *You may upload up to 5 file attachments directly to this PDF.*

Please include the following, if applicable: Diagnostic Assessment, CHIPS petition, Release of Information, Court Orders, Etc

File 1:	Description:	Upload File
File 2:	Description:	Upload File
File 3:	Description:	Upload File
File 4:	Description:	Upload File
File 5:	Description:	Upload File

Submit This Form

Click the Submit button to attach this form to a secure email for submission. You may also upload to our referral page at mncarepartner.com/referrals

Send via eMail Upload to Web Form