Children's Mental Health Case Management Referral Form

Along with the referral please include the following documents.

___ Updated Diagnostic Assessment (Used to determine eligibility)
___ Releases of information for service providers.
___ School documents; 504 plans, IEP, Evaluations.

Date: _____ **Interpreter Needed?** *(indicate language)*: _____

Child's Name: _____

Date of Birth & Age: _____ **Native Heritage:** _____

Guardian #1 Information *(Primary Care Giver)*

Name: _____ **DOB:** _____

Relationship: _____

Address: _____

Child lives with guardian #1 (yes- full time, yes- part time, no): _____

Phone Number: _____ **Email Address:** _____

Guardian #2 Information *(Secondary Care Giver)*

Name: _____ **DOB:** _____

Relationship: _____

Address: _____

Child lives with guardian #2 (yes- full time, yes- part time, no): _____

Phone Number: _____ **Email Address:** _____

Referring Provider Information

Name/ Role: _____

Contact information: _____

Guardian is aware a referral is being submitted to Mower County Health & Human Services: _____

Reason for Referral: _____

_____

_____

_____

_____

Current Service Providers

(Educational, Mental Health, Medical)

Name	***Role***	***Contact information***

Thank you for your referral! We look forward to coordinating with you! For additional questions please email: CMHintake@co.mower.mn.us

Completed referral, along with supporting documents may be

submitted to: Email: CMHintake@co.mower.mn.us

Fax: 507-437-9721 attention: Children's Mental Health

Mail: Mower County Health & Human Services

Attention: Children's Mental Health

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