accend services

Make a Referral

Mental Health / Behavioral Health Services

Name of referred person ______________________ **Birthdate** __________ **Gender** (F) (M)

Address ______________________ **City** __________

State __________ **Zip code** __________ **Phone** __________

Services you are seeking:

- ◯ Adult Rehabilitative Mental Health Services
- ◯ Mental Health Targeted Case Management
- ◯ Children's Skills Training or Behavioral Aide
- ◯ Psychotherapy
- ◯ Diagnostic Assesment

Primary diagnosis (if known) ______________________

Reason for referral:

Current living situation:

- ◯ Private Home/Apt.
- ◯ Foster Care
- ◯ Board & Lodge
- ◯ IRT
- ◯ RTC
- ◯ Nursing Home
- ◯ Homeless/Shelter
- ◯ Jail/Prison
- ◯ Other

Guardian (if any) ______________________ **Phone** __________

Case manager/agency (if any) ______________________ **Phone** __________

Name & agencies of other Mental Health/Behavior Health providers:

Insurance/health care type:

- ◯ Medical Assistance
- ◯ MinnesotaCare
- ◯ VA
- ◯ Medicare
- ◯ Private
- ◯ None

Insurance ID number ______________________ **Requested start date** __________

Name of person making request ______________________ **Phone** __________

Relationship to referred person ______________________

How best to contact:
(list whom to contact, days, hours, times & phone numbers where it is best to reach them)

Signature ______________________ **Date** __________

Call with questions: Toll-free 866.539.0996 | **Duluth & North Shore** 218.724.3122 | **Metro** 612.254.4179
Mail: 101 West 2nd Street Duluth, MN 55802 **Fax:** 218.724.4041