UNIVERSITY OF MINNESOTA

Community-University Health Care Center

Patient Label

APPLICATION FOR ADULT CASE MANAGEMENT SERVICES

* = required

First Name:*	**Last Name:***
DOB:*	**Social Security Number:***
Address:*	**Phone Number(s):***

Status:* ☐ Permanent Resident ☐ US Citizen ☐ Undocumented

Legal Sex:* ☐ M ☐ F ☐ Non-binary

Gender: ☐ Cisgender man ☐ Cisgender woman ☐ Transgender man ☐ Transgender woman ☐ Gender non-conforming

Sexual Orientation: ☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Queer

Ethnicity:* ☐ Hispanic ☐ Non-Hispanic

Race:* ☐ Black ☐ African American ☐ American Indian & Alaska Native ☐ Asian ☐ Native Hawaiian & Other Pacific Islander ☐ White ☐ Race not listed

Language:

Referral Source:	**Referral Date:**

Reason for Referral: ☐ MH Commitment ☐ Community Resources ☐ Homelessness ☐ Symptom Management ☐ Medication Compliance ☐ Navigate Benefits ☐ Interpersonal Relationship/Social ☐ Substance Use ☐ Making Appointments ☐ Transportation ☐ Legal Issues ☐ Frequent ER/Hospitalization ☐ Vocational Support ☐ Other (explain below)

Health Insurance:*	**PMI:***

Diagnosis:*

ICD 10 Code(s):*	**Diagnostic Assessment (DA) Date:***
I consent to receive CM services at CUHCC. **Applicant Signature:**	**Date of Signature:**

INTERNAL USE ONLY

CUHCC Intake CM:	**Date DA expires for intake:**
Assigned CM:	**Case Opened Date:***

SSIS Workgroup #:

For referrals: please fax this form and a DA completed within the past 6 months to (612) 301-1040, ATTN: Nome Thammavong, BH Program Manager.

2024-03