INDEPENDENT HEALTHCARE RESOURCES, LLC (IHR)
ARMHS REFERRAL FORM

FAX # FOR HOME BASED REFERRALS: 651-645-5168

Community-Based Services Intake Referral – Adults (ARMHS)

Client Information

Client Name: _____ Age: _____ DOB: __/__/____ Gender: M ☐ F ☐
Soc. Sec. #: ____ - ___ - _____ Race(s): _____
Address: _____ City: _____ ST: ____ Zip: _____
Home Phone: _____ Work/Cell Phone: _____
Number of adults living in the home: _____ Number of children living in the home: _____

Legal Guardian Information (if adult has a designated guardian)

Legal Guardian's name: _____ Phone: _____

Address: _____ City: _____ ST: _____ Zip: _____

Referral Information

Referral Source: _____ Agency/Division: _____
Phone: ( ) _____ (w/c) Fax: ( ) _____

Current Soc. Serv./Psych. Involvement: Yes ☐ No ☐ If yes, please describe: _____
Current Diagnoses (if any): 1. _____ 2. _____
Current Concerns: _____
_____
Medications: _____

Reason for Referral: _____
_____

Urgent: yes ☐ **no** ☐ If yes, please describe: _____
Therapist Requested: _____

Financially Responsible Party (*please check all that apply*):

☐ Medical Assistance ☐ 3rd Party Insurance
MA #: _____ Carrier: _____
☐ PMAP: _____ Policy Holder: _____
ID #: _____ Policy #: _____
Group #: _____ Group #: _____
☐ County: _____ Prov. Serv. #: ( ) _____ - _____

please include ppwk/cty contract with referral form

Please fax completed referral form, along with ALL of the following (that apply) to (651) 645-1090:
☐ **Current Diag. Assess.** ☐ **Referring Agency Release** ☐ **Referral Source Release** ☐ **County Contract/Ppwk**