Clear Forms

Mental Health and Substance Use Disorder Case Management Referral Form

Product: Select an option

Patient Information

Patient Name:	Date of Birth:	UCare ID#:
Mailing Address:	Phone:	
Language: ☐ English ☐ Burmese ☐ Hmong ☐ Karen ☐ Spanish ☐ Somali ☐ Russian ☐ Other:		Interpreter Needed: ☐ Yes ☐ No

Referral Source

Name of person referring:	Phone:
Clinic/County/Organization:	Email/Fax:

Provider Information (if known)

Primary Care Provider:	Phone/Fax:
Primary Care Clinic:	
MH/SUD Provider/s:	Phone/Fax:
Case Manager/County Worker:	Phone/Fax:
Power Of Attorney / Authorized Representative / Parent:	Phone:

Case Management Criteria

Member must meet one or more of the below criteria in order to be qualified for Mental Health and Substance Use Disorder Case Management:

Check all that apply

☐ 2 admissions in the past 12 months of the following:

- Inpatient mental health, substance use disorder, detox or eating disorder
- Residential Treatment for mental health, substance use disorder, IRTS or eating disorder

☐ 3 admissions in the past 6 months for crisis residential

☐ 2 episodes in the past 12 months for partial hospitalization program

☐ 2 ER visits in the past 6 months for a mental health and/or substance use disorder condition.

Reason for Referral and Recommended Goals

*Attach any supporting documentation that maybe helpful in processing this referral for case management.

Fax to UCare at: 612-884-2033 **Email: MHSUDservices@ucare.org**

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