MENTAL HEALTH DIAGNOSIS AND SERVICES PLAN
MINNESOTACARE/IMCARE PATIENTS

Client Name: ___________________________  Client Number: ___________________________
Client Referred by: ___________________________  Date sent to IMCare: ___________________________

Diagnosis Information

AXIS

I - Psychiatric Illness

Primary: ___________________________

Secondary: ___________________________

II - Personality Disorder or Mental Retardation

Primary: ___________________________

Secondary: ___________________________

III - Medical Diagnosis

Primary: ___________________________

Secondary: ___________________________

IV - Psychological Stressors

Acute: ___________________________

Chronic: ___________________________

V - Level of functioning

Current: ___________________________  Past Year/Baseline: ___________________________

Functional Impairment

(Specific/Behavioral)

TREATMENT/SERVICES

(See MA manual for description of billing units.)

<table>
<thead>
<tr>
<th>UNITS</th>
<th>CODES</th>
<th>SERVICE DESCRIPTION</th>
<th>UNITS</th>
<th>CODES</th>
<th>SERVICE DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>90801</td>
<td>90801</td>
<td>Assessment (1/2 hr units)</td>
<td>90882</td>
<td>90882</td>
<td>Medication Management</td>
</tr>
<tr>
<td>90804</td>
<td>90804</td>
<td>Individual (20-30 min.)</td>
<td>90887</td>
<td>90887</td>
<td>Explanation of finding (1/2 hr units)</td>
</tr>
<tr>
<td>90805</td>
<td>90805</td>
<td>Ind. w/med eval &amp; mgmt (20-30 min)</td>
<td>H2012</td>
<td>H2012</td>
<td>Day Treatment (1 hr units)</td>
</tr>
<tr>
<td>90805</td>
<td>90805</td>
<td>Individual (45-50 min.)</td>
<td>H2014</td>
<td>H2014</td>
<td>Skills Training (15 min. unit)</td>
</tr>
<tr>
<td>90807</td>
<td>90807</td>
<td>Ind. w/med eval &amp; mgmt (45-50 min.)</td>
<td>H2015</td>
<td>H2015</td>
<td>Crisis Assistance (15 min. unit)</td>
</tr>
<tr>
<td>90847</td>
<td>90847</td>
<td>Family w/o patient (1/2 hr units)</td>
<td>H0048</td>
<td>H0048</td>
<td>Travel (1 min. unit)</td>
</tr>
<tr>
<td>90853</td>
<td>90853</td>
<td>Group (1/2 hr units)</td>
<td>90101</td>
<td>90101</td>
<td>Testing (1 hr units)</td>
</tr>
</tbody>
</table>

Referred to: ___________________________

Consultation Only

Transfer to Other Therapist

Referral for Auxiliary Service within Basic Package

Provider Name: ___________________________

Provider Signature: ___________________________

Provider Number: ___________________________

FOR IMCare OFFICE USE ONLY

MA/QA Review: ___________________________  Date: ___________________________

Clinical Consult:  ☐ No  ☐ Yes (attach narrative)  Referral Number: ___________________________

Form date: 3/01; updated 1/04, 11/04; reviewed: 8/06
ITASCA COUNTY MENTAL HEALTH SERVICES
CLIENT ADMISSION TO COUNTY PROGRAM

FROM THE PROVIDER OFFICE OF:

CASE MANAGER: ____________________________
APPLICATION DATE: ________________________
NEW: ____ CHANGE: __________
CLIENT NAME: _____________________________
ADDRESS: __________________________________
CITY: __________________ STATE: ______ ZIP: ______
Referral Source Code: ______________________

ELIGIBILITY FOR COUNTY PROGRAM
Annual Gross Income: _______________ Family Size: __________
Does client meet income eligibility test? ______
Do you have proof of MA denial? ______ Source: ______________
If no MA denial, do you have a request for services from an ICHS social worker? ______ (Attach copy)
Client's income exceeds MA guidelines? ______
Comments: ________________________________________________

CLIENT INFORMATION
Member mailing address if different than above:
____________________________________________________________________
Telephone Number: ____________________________ Member's DOB: ______
Member's Sex: __________ Marital Status: ______
SSN: ____________
Medicare: A ___ B ___ A&B ___ Medicare Number: ____________
OHC: Yes ___ No ___ Name of Insurance Co. ________________
Sliding Fee? No ___ Yes ___ (Attach schedule with amount circled)
Release of clinical information to primary physician? Yes ___ No ___
Name of physician: ____________________________________________

Client Signature (if available) Date __________ Approve ___ Deny ___
Initials: ________________________________________________