MENTAL HEALTH DIAGNOSIS AND SERVICES PLAN
MINNESOTACARE/IMCARE PATIENTS

_____Initial _____Change in Services _____Court Ordered _____MinnesotaCare

Client Name _____ Client Number:_____ Date of Birth:_____

Client Referred by:_____ Date sent to IMCare:_____ IMCare Service Start Date:_____

DIAGNOSTIC INFORMATION

AXIS	CODES	DESCRIPTION
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.)

UNITS	CODES	SERVICE DESCRIPTION	UNITS	CODES	SERVICE DESCRIPTION
	90801	Assessment (1/2 hr units)		90862	Medication Management
	90804	Individual (20-30 min.)		90887	Explanation of finding (1/2 hr units)
	90805	Ind. w/med eval & mgmt (20-30 min)		H2012	Day Treatment (1 hr units)
	90806	Individual (45-50 min.)		H2014	Skills Training (15 min. unit)
	90807	Ind. w/med eval & mgmt (45-50 min.)		H2015	Crisis Assistance (15 min. unit)
	90846	Family w/o patient (1/2 hr units)		H0046	Travel (1 min. unit)
	90847	Family w/patient (1/2 hr units)		96101	Testing (1 hr units)
	90853	Group (1/2 hr units)	3	T2023	Other CHILD TCM

Referred to:_____ Provider Name:_____

_____Consultation Only Provider Signature:_____

_____Transfer to Other Therapist Provider Number:_____

_____Referral for Auxiliary Service within Basic Package

FOR IMCare OFFICE USE ONLY

MA/QA Review::_____ Date:_____ Referral Number:_____

Clinical Consult: ☐ No ☐ Yes (attach narrative)

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 Numbe _____ 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 _____