Services	Phone Numbers
Administrative	(218) 824-1140
Child Support	(218) 824-1260
Community Corrections	(218) 824-1135
Health Services	(218) 824-1080
Income Maintenance	(218) 824-1250
Social Services	(218) 824-1140
Toll free	(888) 772-8211

COMMUNITY SERVICES
204 LAUREL ST.
P.O. BOX 686
BRAINERD, MN 56401
WWW.CROWWING.GOV
FAX (218) 824-1141
EMAIL CWCSS@CROWWING.GOV

OUR MISSION: SERVE WELL. DELIVER VALUE. DRIVE RESULTS.

CWC-1062
02/24

Community Services Referral for AMH/SUD

Date: _____

Client Information:

Name: _____ Date of Birth: _____ SSN: _____

Home Address: _____ City: _____ Zip: _____

Other Address: _____ City: _____ Zip: _____

Phone: _____ Email: _____

Referent information:

☐ Self- Referral (CWC Walk-ins) Assisted by: _____

☐ Agency Referral: _____ Individual Contact: _____

Role: _____ Phone: _____ Fax: _____ Email: _____

Does Client know of this Referral? ☐ Yes ☐ No Does the client WANT services? ☐ Yes ☐ No

What is the current need/request from Crow Wing County Community Services?

☐ **Mental Health Case Management -**
Adult Mental Health Case Management consists of assisting the person in obtaining supports and services to medical/Mental, social, educational, and other services necessary to meet the person' mental health needs and goals. There are eligibility requirements for this service.

☐ **Substance Use Disorder Care Coordination -**
Substance Use Disorder Care Coordination consists of assisting a person with obtaining services, assessments, referrals, and access to programs and supports for their substance use. There are eligibility requirements for this service.

☐ **Other** -

_____

Please briefly describe specific needs and supports looking for:

_____

_____

Health Insurance:

PMI or MA#: _____ County of Financial Responsibility: _____ PMAP: _____

Medicare Number: _____ Medicare part D provider: _____

Do you have Private Health insurance? ☐ No ☐ Yes (List) _____

Does individual have a:

Social Worker: ☐ No ☐ Yes - If yes, County: _____ Phone: _____

Child Protection Social Worker: ☐ No ☐ Yes - If yes, County: _____ Phone: _____

Probation Officer: ☐ No ☐ Yes - If yes, County: _____ Phone: _____

Mental Health - Primary Diagnosis:

☐ Schizophrenia ☐ Schizoaffective Disorder ☐ Borderline Personality Disorder

☐ Major Depressive Disorder ☐ Bipolar Disorder ☐ Other: _____

☐ Other Diagnoses: _____

Other Community Mental Health Supports In Place (i.e Psychiatrist, ARMHS, etc.):

☐ ARMHS/ICTS: _____ ☐ Counselling: _____

☐ Psych Med. Management:_____ ☐ ACT Team: _____

☐ IHS/PCA:_____ ☐ AFC/CRS: _____

☐ Other: _____

Alcohol/Drug:

Diagnoses: _____

Drug of Choice: _____ Date of last Use: _____

Date of last Assessment: _____ What Agency completed it: _____

Medical:

Medical Diagnoses/Health Problems: _____

Medication List: _____

Who is prescribing Physician? _____ Pharmacy used? _____

Primary Physician Name: _____ Clinic Name and Phone Number: _____

Transportation Method(s):

☐ Own Vehicle ☐ Walk ☐ Bus ☐ Friends/Family ☐ Other: _____

Financial:

Income = (List type(s) & amount(s)): _____

Rep Payee? ☐ No ☐ Yes - If yes, who? _____ Phone Number: _____

Guardian/Conservator? ☐ No ☐ Yes - If yes, who? _____

If yes, Agency: _____ Phone Number: _____

Please attach any applicable Information to referral. (i.e. – Med list, ROI, Applicable Assessment, etc.)