Hennepin County AMH-TCM Contracted Provider

Intake/Opening Form

Return this form in an encrypted email to: [HSPH.OS.BH@hennepin.us](mailto:HSPH.OS.BH@hennepin.us)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Person’s last name |  | | | |
| Person’s first name |  | | | |
| SSN |  | Person’s date of birth | |  |
| **Verify eligibility by calling 612-348-4111 or email socialservices@hennepin.us** | | | | |
| Date of verification |  | Hennepin staff who verified eligibility | |  |
| County of Financial Responsibility (CFR) |  | Person’s insurance provider | |  |
| PMAP |  | PMI number | |  |
| Is the person a Hennepin County resident? |  | Is the person eligible for case management services in Hennepin? | |  |
| Is the person open to other Hennepin County services? |  | | | |
| Date of diagnosis/DA (must be within the last 6 months) |  | Name of primary diagnosis | |  |
| ICD 10 score |  | WHODAS score (optional) | |  |
| Case opening date |  | | | |
| Provider name & Program |  | | | |
| Supervisor |  | | Phone | |
| Case Manager |  | | Phone | |
| Include an ***Information Disclosure NonEPIC/Tennessen Notice*** signed by the person with this form, in an encrypted email to: [HSPH.OS.BH@hennepin.us](mailto:HSPH.OS.BH@hennepin.us) | | | | |