

**Intensive Community Based Services**  
Initial Request Form



Your Agency name: \_\_\_\_\_

Name of Agency staff who met with client: \_\_\_\_\_

Agency staff phone number: \_\_\_\_\_

Date of Initial Screening/meeting with client: \_\_\_\_\_

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent/Guardian Name if a minor: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Are they currently involved in Rule 79? Y  N

Are they eligible for Rule 79? Y  N

**Diagnosis:** \_\_\_\_\_

**SX:** Sadness  Mania  Low energy  Low Motivation  Angry  Anxiety  Sleep  Impulsive  Compulsive   
Delusions  Hallucinations  Disorganized Speech  Obsessive  Concentration  IQ/Cognitive issues   
Difficulty completing activities of daily living (ADL's)  Aggressive  Truant  Runaway  Disorganized Behavior

**Stressors:** Economic Housing  Occupational  Legal  Social  School  Family Relationships

**Support System:** \_\_\_\_\_

**Current Medical Symptoms:** \_\_\_\_\_

**Substance Abuse Assessed:**  Y  N **Problem?**  Y  N (note below if referrals made)

**Risk Assessment:** *Suicidality:* None  Ideation  Plan  *Homicidality:* None  Ideation  Plan

\*Contracting for safety? Self \_\_\_\_\_ Others \_\_\_\_\_

**Medications:**  Y  N **Med List:** \_\_\_\_\_

In the last 7 days, how many days were medications taken as prescribed? \_\_\_\_\_ (#of days)

In the past month, how many appointments were scheduled? \_\_\_\_\_ How many were kept? \_\_\_\_\_

**Treating Providers:** \_\_\_\_\_

**Current Client Needs:** \_\_\_\_\_

**Planned Interventions/Goals:** \_\_\_\_\_

**Barriers:** \_\_\_\_\_

**Referrals Made:** \_\_\_\_\_

**Authorization start date:** \_\_\_\_\_

**For HDC or Central MN Mental Health ONLY:**

Location: Urban  Rural