PEOPLE INCORPORATED
MENTAL HEALTH SERVICES

Children's Targeted Case Management Referral Form

CLIENT INFORMATION	
Client Name:	**Date of Referral:**
Birthdate:	**Legal Sex:**
Insurance Plan:	**Policy #:**
Parent/Guardian:	
Address:	
Parent Email:	**Parent Phone:**
County of financial responsibility:	
Does the client have a Diagnostic Assessment or Neuropsych Eval? ☐ **YES** ☐ **NO**	
If yes, where was it completed:	**Date:**
Does the client have an IEP? ☐ **YES** ☐ **NO**	
If yes, what school District:	**Date:**
If you answered yes to either of the above, please include a copy of those documents with this referral form.	

REFERRER INFORMATION	
Referred By:	**Agency:**
Relationship to client:	
Email:	**Phone:**

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Please indicate which of the following services you would like help in obtaining for the child:

- ☐ Individual and/or Family Therapist
- ☐ Individual and/or Family CTSS Skills Worker
- ☐ Individualized Education Plan (IEP)
- ☐ Psychiatrist
- ☐ Primary Care Physician
- ☐ Dentist
- ☐ Health Insurance
- ☐ Other

In addition to the services listed above, please provide additional information indicating why you are seeking mental health targeted case management services for this client:

Please submit completed referral form and supporting documents such as DA, Psych Eval and IEP to People Incorporated

- **By email: CFS.Admin@PeopleIncorporated.org**
- **By fax: 763.331.3039**
- **By mail: People Incorporated**
  5555 Boone Avenue North
  New Hope, MN 55428

Please contact us at 763.331.3033 with any questions