University of Minnesota

Community-University Health Care Center

Patient Label

APPLICATION FOR CASE MANAGEMENT SERVICES

<table>
<tr><td colspan="2">Last Name:</td><td colspan="2">First Name:</td></tr>
<tr><td colspan="2">Sex: M ☐ F ☐ M to F ☐ F to M ☐</td><td colspan="2">Date of Birth::</td></tr>
<tr><td colspan="4">Address:</td></tr>
<tr><td colspan="2">Phone Number:</td><td colspan="2">Cell Phone Number:</td></tr>
<tr><td colspan="4">Social Security Number:</td></tr>
<tr><td colspan="4">Referral Source:</td></tr>
<tr><td colspan="4">Reason for Referral:</td></tr>
<tr><td colspan="2">PMI:</td><td colspan="2">Health Insurance:</td></tr>
<tr><td colspan="3">Diagnosis (include DSM Codes):</td><td>Date of Diagnosis:</td></tr>
<tr><td colspan="4">CUHCC Intake:</td></tr>
<tr><td colspan="3">I consent to receive CM Services at CUHCC.

Applicant Signature:</td><td>Date:</td></tr>
<tr><td colspan="4">Case Opened Date:</td></tr>
<tr><td colspan="4">Assigned Case Manager:</td></tr>
</table>

For a referral, please fax (612-301-1040) a diagnostic assessment completed within the past 6 months to ATTN: Nome Thammavong, BH Program Manager.