Alpha Care LLC ARMHS Program Referral Form

Version 05/28/2025

Please email this form to info@alphacarellc.org or fax to 218-986-0894

Referral Source Information

*Name:		*Phone Number:	
*Agency:		*Relationship to Client:	

Client Information

*Legal Name:		*Legal Gender:	
*Preferred Name:		*Gender Identity & Pronouns:	
*Date of Birth:		*Primary Phone Number:	
Email:		Secondary Phone Number:	
*Residential Address:			

Insurance Information

Insurance 1 Type:		Insurance 1 Company:	
Insurance 1 ID/PMI:		Insurance 1 Policy Holder:	
Insurance 2 Type:		Insurance 2 Company:	
Insurance 2 ID/PMI:		Insurance 2 Policy Holder:	
Insurance 3 Type:		Insurance 3 Company:	
Insurance 3 ID/PMI:		Insurance 3 Policy Holder:	

Insurance Information

1. ***Why are you referring the client for ARMHS?**

2. *What goal(s) is/are the client hoping to work on with ARMHS?

- ☐ INTERPERSONAL COMM
- ☐ EMPLOYMENT RELATED SKILLS
- ☐ MENTAL ILLNESS SYMPTOM MGMT
- ☐ MEDICATION MONITORING
- ☐ HOUSEHOLD MGMT
- ☐ COMMUNITY INTEGRATION
- ☐ CRISIS ASST
- ☐ Other
- ☐ TRANSITIONING TO COMMUNITY LIVING
- ☐ BUDGET/SHOPPING/LIFESTYLE SKILLS
- ☐ RELAPSE PREVENTION

3. *Does the client have a preferred language other than English? If yes, please list below and do they need an interpreter.

Yes: ☐ No: ☐

4. *Are there any safety concerns Alpha Care LLC should be aware of for this client and ARMHS Practitioners? If yes, please elaborate.

Yes: ☐ No: ☐

5. *Please describe the client's mental health and substance use treatment history?

6. *Does the client have a legal guardian? If so, what is their name and contact information (email and phone number).

Yes: ☐ No: ☐

7. Does the client have any mental health triggers Alpha Care LLC should be aware of? If yes, please elaborate.

Yes: ☐ No: ☐

8. *Does the Client have a Case Manager/Social Worker/Care Coordinator? If yes, please include their contact information.

Yes: ☐ No: ☐