Revised 1/4/2021

Independent Management Services
ARMHS Referral

Client's full name:		**Gender: ☐ Male ☐ Female**
Date of Birth:		**Social Security Number:**
Last Known Permanent Address:	**City:**	**State: Zip:**
Phone:	**Current Placement or Location:**	
Medical Assistance Number (PMI):	**Other Insurance Name:** **ID #: Group #:**	
Referred by:		
Guardian: **☐ Yes ☐ No**	**Name of Guardian:** **Address:** **Phone:**	
Case Manager: **☐ Yes ☐ No**	**Name of Case Manager:** **Agency:** **Address:** **Phone:**	
Therapist: **☐ Yes ☐ No**	**Name of Therapist:** **Name of hospital or agency:** **Address:** **Phone:**	

Do you have a diagnostic assessment no less than 180 days old completed by a mental health professional recommending ARMHS services? ☐ Yes ☐ No

******Please assist this person in completing an ROI with the agency who completed the last diagnostic assessment. This will speed up the process. Have the agency send the DA to IMS.*******

Is the diagnostic assessment attached to this form? ☐ Yes ☐ No

If no, is this person willing to meet with a mental health professional to complete a diagnostic assessment?
☐ Yes ☐ No

******* Please assist them in setting up a diagnostic assessment in your local community with their current MHP or a new clinician. Assist them in completing an ROI at this agency for IMS.*******

Do you have any pertinent records to contribute? (Functional Assessment, LOCUS, ITP,) ☐ Yes ☐ No

Has this person even been diagnosed with a mental illness? ☐ Yes ☐ No
If so, what conditions?

Is this person seeking services voluntarily? ☐ Yes ☐ No

Please complete and submit by US mail, fax or email to:

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