BrightStep Wellness Center

Mental Health /Behavioral Health Services

Name of referred person _____ **Birthdate** _____ **Gender** M ◯ F ◯

Address _____ **City** _____

State _____ **Zip Code** _____ **Phone** _____

Services you are seeking:

- ◯ Adult Rehabilitative Mental Health Services
- ◯ Mental Health Targeted Case Management
- ◯ Children's Therapeutic Services and Supports (CTSS)
- ◯ Diagnostic Assessment
- ◯ Housing Stabilization

Primary diagnosis (if known) _____

Reason for referral

Current living situation:

- ◯ Private Home/Apt.
- ◯ Foster Care
- ◯ Board & Lodge
- ◯ IRT
- ◯ RTC
- ◯ Nursing Home
- ◯ Homeless/Shelter
- ◯ Jail/Prison
- ◯ Other

Guardian (if any) _____ **Phone** _____

Case manager/agency (if any) _____ **Phone** _____

Name & agencies of other Mental Health/Behavioral Health providers:

Insurance/health care type:

- ◯ Medical Assistance
- ◯ MinnesotaCare
- ◯ VA
- ◯ Medicare
- ◯ Private/Commercial
- ◯ None

Insurance carrier (ie. Medica) _____ **Insurance ID number** _____

Requested start date _____

Name person making request _____ **Phone** _____

Relationship to referred person _____

How best to contact:
(list whom to contact, days, hours, times & phone numbers where it is best to reach them)

Signature _____ **Date** _____

Call with questions: **Office Phone** 612-800-2441 | **Fax:** 612-778-8765

Office Address: 3300 5th St NE STE201 Minneapolis, MN 55418

If possible, please attach Diagnostic Assessments, Release of Information, Eligibility Determinations and other applicable documents