Mental Health and Substance Use Disorder
Case Management Referral Form

Product: Individual and Family Plan

Patient Information		
Patient Name:	Date of Birth:	UCare ID#:
Mailing Address:	Phone:	
Language: ☐ English ☐ Burmese ☐ Hmong ☐ Karen ☐ Spanish ☐ Somali ☐ Russian ☐ Other:		Interpreter Needed: ☐ Yes ☐ No

Referral Source	
Name of person referring:	Phone:
Clinic/County/Organization:	Email/Fax:

Provider Information (if known)	
Primary Care Provider:	Phone/Fax:
Primary Care Clinic:	
MH/SUD Provider/s:	Phone/Fax:
Case Manager/County Worker:	Phone/Fax:
Power Of Attorney / Authorized Representative / Parent:	Phone:

Case Management Selection

Member must meet one or more of the below criteria to be qualified for Mental Health and Substance Use Disorder Case Management:

Check all that apply

☐ Member has a mental health condition or substance use disorder and a need for more support is identified
☐ Member has a diagnosis of Autism or a related condition

Reason for Referral and Recommended Goals

*Attach any supporting documentation that maybe helpful in processing this referral for case management.

Fax to UCare at: 612-884-2033 Email: MHSUDcasemanagement@ucare.org