



Mental Health Targeted Case Management Universal Transfer Form

This form should be used to transfer mental health targeted case management cases from:

- County to county
- Tribal agency to county
- County to tribal agency
- County to community provider
- Community provider to community provider
- Community provider to county
- Community provider to tribal agency
- Tribal agency to community provider.

The Universal Transfer Form should be completed by the current mental health targeted case manager and sent to the new mental health targeted case manager as soon as the need for a transfer of responsibility is known. Some health plans are interested in receiving the form upon completion as well. Relevant documents (e.g., the Individual Community Support Plan Diagnostic Assessment or the Individual Family Community Support Plan) can be attached to this form to further facilitate the transfer assuming proper client consent is in place. Completion of this transfer form does not establish a prospective provider as financially responsible for the delivery of mental health targeted case management services.

TODAY'S DATE			
TO			
<input type="checkbox"/> Health plan <input type="checkbox"/> County <input type="checkbox"/> Community provider <input type="checkbox"/> Tribal agency			
FROM			
<input type="checkbox"/> Health plan <input type="checkbox"/> County <input type="checkbox"/> Community provider <input type="checkbox"/> Tribal agency			
CURRENT MENTAL HEALTH TARGETED CASE MANAGER		PHONE NUMBER	FAX NUMBER
<input type="checkbox"/> Health plan <input type="checkbox"/> County <input type="checkbox"/> Community provider <input type="checkbox"/> Tribal agency			
REASON FOR TRANSFER			
Member/client information			
NAME		DATE OF BIRTH	PHONE NUMBER
PMI NUMBER	PARENT/GUARDIAN (if applicable)		
HOME ADDRESS		CITY	STATE ZIP CODE
MAILING ADDRESS (IF DIFFERENT FROM HOME ADDRESS)		CITY	STATE ZIP CODE

Please complete the following fields if the information is not included in an attached Individual Community Support Plan or Individual Family and Community Support Plan

CURRENT ISSUE(S) – In what areas does the client currently require assistance?

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Mental health symptoms | <input type="checkbox"/> Mental health service needs | <input type="checkbox"/> Use of drugs/alcohol | <input type="checkbox"/> Educational functioning |
| <input type="checkbox"/> Social functioning/leisure | <input type="checkbox"/> Interpersonal functioning | <input type="checkbox"/> Self-care capacity | <input type="checkbox"/> Medical health |
| <input type="checkbox"/> Medication concerns | <input type="checkbox"/> Dental health | <input type="checkbox"/> Obtain/maintain financial assistance | <input type="checkbox"/> Obtain/maintain housing |
| <input type="checkbox"/> Using transportation | <input type="checkbox"/> Other: _____ | | |

Does member/client direct own care? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF NO, WHO IS RESPONSIBLE (NAME AND CONTACT INFORMATION)?	
REPRESENTATIVE PAYEE/AUTHORIZED REPRESENTATIVE <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, NAME	
FINANCIAL WORKER <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, NAME	
LANGUAGE NEEDS <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, SPECIFY	
SPECIAL NEEDS (e.g., limited mobility) <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, SPECIFY	
COURT INVOLVEMENT (e.g., current civil commitment) <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, SPECIFY	
PRIMARY CARE CLINIC	PHYSICIAN	
PSYCHIATRIST	CARE COORDINATOR	

Contact information for health plans and tribes

Health plan/Tribe	Phone number	Fax number
Blue Plus	(800) 262-0820	(651) 662-6054
Health Partners	(952) 883-7998	(952) 883-6139
Medica	(800) 848-8327	(952) 992-2002
Metropolitan Health Plan	(800) 647-0550	(612) 904-4265 (MSHO) (612) 348-3195 (SNBC)
U-CARE	(800) 203-7225	(612) 884-2057 (MSHO, MSC+, SNBC)
Prime West	(866) 431-0801 or call county of residence	
South Country Health Alliance	(866) 567-7242	
Itasca Medical Care	(800) 843-9536	
Fond du Lac	(218) 878-2104	(218) 878-2198
Leech Lake Band of Ojibwe	(218) 335-4500	(218) 335-8219
White Earth Tribal Band	(218) 983-3285	(952) 992-2002