PEOPLES DEVELOPMENT SERVICES
St. Paul Office: 665 Snelling Ave N, St Paul, MN 55104
Minneapolis Office: 3617 E. Lake Street Ste A-3, Minneapolis, MN 55406
Phone: 612-332-9124 Fax: 612-332-9867 Email: contact@pdsminn.org
www.pdsminn.org

ARMHS Increased Service Frequency Recommendation Form

External Provider Information:

Date of Recommendation: _____

Name: _____ Agency:_____

Position:_____ Email:_____

Phone:_____ Fax:_____

Client's Information:

Client Name: _____Date of Birth: _____

Reason for Recommendation:

Based on the client's current mental health needs and level of functioning, please indicate whether you recommend that the client receive ARMHS services more than once per week.

Do you recommend at least two ARMHS visits per week?

☐ No ☐ Yes ☐ Yes, temporarily, until _____

Reason for Recommendation *(Please check all that apply):*

☐ Increased mental health symptom management is needed
☐ Client needs additional support with daily living skills
☐ Client needs additional monitoring and support to maintain stability
☐ Client is having difficulty functioning independently
☐ Client needs additional support with community resources
☐ Client needs additional support with interpersonal/social skills
☐ Client needs support with budgeting, shopping, or healthy lifestyle skills
☐ Client needs support with household management
☐ Client needs support with employment-related skills
☐ Other: _____

Recommended ARMHS Skill Areas:

Please identify the areas where additional MHP support would be beneficial:

☐ Mental health symptom management ☐ Interpersonal communication and social skills
☐ Using community resources. ☐ Budgeting and shopping ☐ Healthy lifestyle skills
☐ Household management. ☐ Employment-related skills ☐ Independent living and community skills
☐ Other: _____

Client Recommended Frequency:

Current PDS service frequency: ☐ Once per week

Recommended frequency: ☐ Twice per week. ☐ Three times per week. ☐ Other: _____

Recommended duration of increased services:

☐ 30 days. ☐ 60 days. ☐ 90 days. ☐ Until further review ☐ Other: _____

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Additional Comments/Clinical Recommendation:

Please briefly explain why increased ARMHS visits would benefit the client:

_____
_____
_____
_____
_____
_____

Provider Confirmation:

I recommend the increased frequency of ARMHS services identified above based on the client's current needs and functioning.

Provider Name: _____Title/Credentials:_____

Signature: _____Date: _____

Return Form To; Email at contact@pdsminn.org or email the client's assigned mental health practitioner.

Peoples Development Services (PDS) ARMHS Program

Please return the completed form to the PDS ARMHS program by email or other designated method.

PDS Contact: _____Phone: _____

Email: _____