



PEOPLES DEVELOPMENT SERVICES

St. Paul Office: 665 Snelling Ave N, St Paul, MN
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 Recipient Record - Recipient Intake

This cover sheet and intake is used to review and verify that the service recipient record is maintained according to applicable licensing requirements and associated rules.

Personal Information

First Name: _____ M.I.: _____ Last Name: _____
Date of Birth: _____ Social Security Number: _____
Address: _____ City: _____ Zip: _____
Phone Number: _____ Email: _____

Source of Referral

Name: _____ Agency: _____
Position: _____ Email: _____
Phone: _____ Fax: _____

Living Arrangement

☐ Lives alone ☐ Lives with spouse ☐ Lives with family ☐ Other: _____

Emergency contact information #1

First name _____ Last Name: _____
Phone: _____ Email: _____

Emergency contact information #2

First name _____ Last Name: _____
Phone: _____ Email: _____

Health Care / Provider Contact Information

Physician / Clinic: _____
Phone number: _____ Fax number and/or email: _____
Case Manager / Agency: _____
Phone number: _____ Fax number and/or email: _____
Therapist / Clinic: _____
Phone number: _____ Fax number and/or email: _____

Specific Needs of The Client

(1) Developmental Status:

(2) Cognitive Functioning:

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(3) Physical and Mental Abilities:

(4) Other significant medical and health-related needs

Required Documentation Completed in Recipient Record

Required Documentation Completed in Recipient Record	Document Title	Staff Initials	Date Reviewed or Completed
Client rights and protections	Policies in Regards to Client Rights		
Grievance policy/procedure	Grievance Policy and Procedure		
Data Privacy - HIPAA and MN Health Records Act	Notice of Privacy Practices / HIPAA-MHRA-Data Privacy		
Maltreatment of Vulnerable Adults	Maltreatment of Vulnerable Adults Mandated Reporting		
Maltreatment of Minors	Maltreatment of Minors Mandated Reporting		
Screenings, assessments, and testing	DA's, FA's		
Treatment plans and reviews of the client's treatment plan	ITP		
Health care directive	Minnesota Health Care Directive Template		
Crisis plan	N/A - Fill out below		
Consents for releases of information as applicable	FORM - Minnesota Standard Consent form to release health information		
Discharge summary if applicable	FORM - Discharge summary form		

Written Information by the client that the client requests to include in the client's file

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Crisis and Relapse Prevention Plan

Client Name: _____ Date: _____

1. My mental health diagnosis is:

2. Three symptoms I experience with my illness that give me the most difficulty are:

- a. _____
- b. _____
- c. _____

3. These stressful events endangered my mental health and put me in crisis:

- a. _____
- b. _____
- c. _____

4. These are things I can do to handle stressful events in the future:

- a. _____
- b. _____
- c. _____

5. Current pressures or stressors in my life are:

- a. _____
- b. _____
- c. _____

6. Three ways that I think I can reduce my stress are:

- a. _____
- b. _____
- c. _____

7. Three of my positive qualities and/or strengths are:

- a. _____
- b. _____
- c. _____

8. Supportive friends and/or family that I can call on a regular basis are:

- a. _____
- b. _____
- c. _____

9. A daily community/leisure/healing activity I will engage in is:

- a. _____
- b. _____
- c. _____

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10. A negative or destructive activity I will avoid is:

- a. _____
- b. _____
- c. _____

11. Three steps I will take to prevent relapse when my symptoms and/or warning signs return or become worse:

- a. _____
- b. _____
- c. _____

12. If my symptoms and/or warning signs return and I feel I am relapsing, I will:

- a. _____
- b. _____
- c. _____

13. The community settings where I will likely receive ARMHS services are the following:

- a. _____
- b. _____
- c. _____

14. The following items could affect my health and safety while ARMHS services are delivered to me or my staff, out in the community, and our plan (if applicable) is below:

- a. _____
- b. _____
- c. _____

At any time, I can call or text MN to 741741 as an additional resource for me.

Area Mental Health Crisis Response Phone numbers:

Anoka: 763-755-3801, Carver/Scott: 952-442-7601, Ramsey: 651-266-7900,

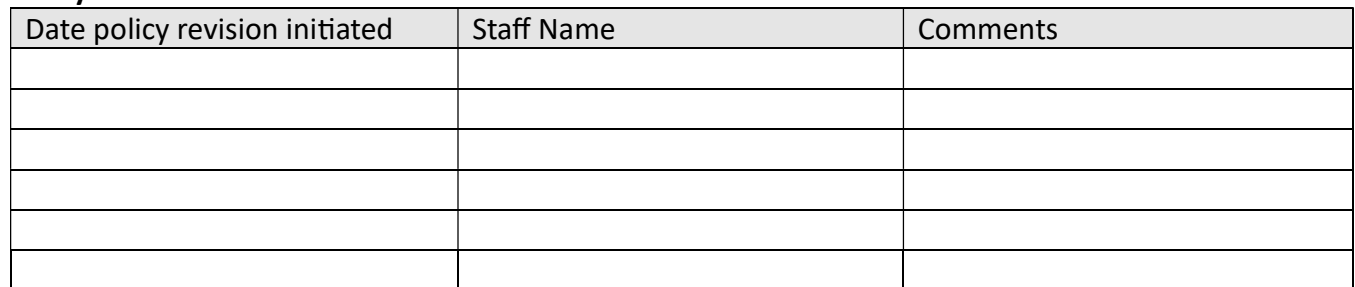
Hennepin: 612-596-1223, Dakota: 952-891-7171, Washington: 651-777-5222,

Sherburne: 800-635-8008, Olmsted: 1-844-274-7472, Stearns: 800-635-8008

Call 911 if the steps above do not help me de-escalate and I feel like I cannot maintain my safety.

Name	Signature	Title	Date
		Recipient	
		Participant's Caregiver	
		Staff Member	

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Authorization For Release of Medical Information

Client Name: _____ Date of Birth: ____/____/____

Clinic Name: _____ Clinic Fax: _____

I authorize Peoples Development Services (PDS) to exchange with clinic: _____

I (Client Name) _____ authorize PDS to release and exchange (both releasing and obtaining) of the following protected health information:

Information to be released:

- ☐ Medical History/Summary
- ☐ Medical Reports
- ☐ Assessment/Diagnostic Findings
- ☐ Psychiatric Evaluation
- ☐ Discharge Summary
- ☐ Chemical Dependency History/Assessment Reports & Treatment Records
- ☐ Progress Notes
- ☐ Education/School Records
- ☐ Medical Treatment Plan
- ☐ Other: _____

Purpose of releasing information:

- ☐ Continuing Care
- ☐ Behavioral Health Treatment
- ☐ Client Request
- ☐ Coordination of Services
- ☐ Social Security Income or Benefits

This consent expires automatically twelve (12) months from the date this consent is signed, unless revoked by me.

I understand that I may cancel this authorization at any time. To cancel this authorization, I must notify PDS in writing. This authorization will be canceled once PDS has received my written notice. The expectation to this would be if it would be if my information has already been released prior to me signing this authorization. In that case, this information would not have been protected by federal privacy regulation.

Client Signature

____/____/____
Date

Parent/Legal Guardian

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Release of Information Consent Form

I, _____, Birthday ____/____/____ authorize Peoples Development Services (PDS) to:

- ☐ Exchange with the following individual(s) or entity(ies): _____
- ☐ Obtain from the following individual(s) or entity(ies): _____
- ☐ Release to with the following individual(s) or entity(ies): _____

The Following information:

- ☐ Social Security Disability ☐ Bio/Psycho/Social ☐ Progress Notes/Treatment Plan Review
- ☐ Psychological Information ☐ Rule 25 Assessment & Referrals ☐ Housing & Employment Info
- ☐ County Benefits & MNsure ☐ Discharge/Treatment Summary ☐ Other: _____

The purpose for this disclosure is: _____

This consent expires automatically twelve (12) months from the date this consent is signed, unless revoked by me. I understand that my records are protected under the Minnesota Government Data Privacy Act (Minn. Stat. Chapter 13), the Health Insurance Portability and Accountability Act of 1996 (45 CFR Parts 160, 162, and 164), and other applicable state and federal privacy laws. I understand that this information cannot be released without my written consent, unless otherwise authorized by law, and that I am under **NO OBLIGATION** to release it. I understand that I may release all, some, or none of the information. I understand that if there is a child protection hearing, the information collected from me will become public if submitted in a report to the court or if introduced as evidence pursuant to Minnesota Rules 44.01 and 44.02 of the Rules of Juvenile Procedure, except for the data specifically listed in Rules 8.01 through 8.08 of the Minnesota Rules of Juvenile Procedure. I understand that I have a right to see the information and have a copy of it. I may revoke this Consent at any time in writing, however, revocation will not pertain to data released or obtained prior to the County's receipt of the written revocation notice at one of the addresses noted above. Unless I revoke my consent sooner, my permission to allow the release of this information will automatically expire one (1) year from the date I sign this release. I understand that in accordance with 45 CFR part 164.508, subd. c (2) (iii), you are informing me that the individual(s) or entities whom you are authorized to disclose my information to may not be subject to the same privacy rules as PDS and there may be the potential for redisclosure of the private information. I understand that my eligibility to receive benefits from PDS Social Services will not be affected if I refuse to sign this release. However, I also understand that if I refuse to sign this Consent, it could affect the County's ability to determine what services I need or am qualified to receive.

Date: ____/____/____ Client Signature: _____

Person Requesting Release: _____

Witness Parent/Guardian: _____
(If client under 18 or under legal Guardianship)

Please fax or email the consent to form: Fax: 612-332-9867 or contact@pdsminn.org

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Client Expectations and Cancellation Policy

Client Expectations:

1. Client will commit to meeting with staff weekly.
2. Client will contact staff if they are unable to make a scheduled appointment, with at least 24 hours notice.
3. Client will reply to calls, text or emailed from staff with 24 hours.
4. Client will notify staff if they have a new number or have lost their cell phone. If you have lost your staff's phone number clients can call the main number listed above.
5. Client will notify staff if they have an address that has changed within 3 days.

Cancellation Policy:

Peoples Development Services is committed to providing quality services and support to our clients, we understand that unforeseen circumstances may arise that require the cancellation or rescheduling of appointments. To ensure the smooth functioning of our services and to best meet the needs of all clients, we have established the following cancellation policy:

1. **Notice of Cancellation:** Clients are kindly requested to provide at least 24 hours' notice when canceling or rescheduling an appointment. This allows us to offer the time slot to another client in need.
2. **Contact Information:** Clients are responsible for ensuring that the contact information on file with the staff is current. This includes email addresses and phone numbers. We will make every effort to confirm appointments in advance to avoid any misunderstandings.
3. **Late Cancellations and No-Shows:** Cancellations made with less than 24 hours' notice will be considered late cancellations.
4. **Repeated Cancellations:** If a client demonstrates a pattern of repeated cancellations or no-shows, the staff may need to reevaluate the client's appropriateness of being an active client. After 4 late cancellations or no shows you will be discharged from the program or service will be on hold.
5. **No Response:** Clients are expected to respond to voice messages, text messages or emailed within 24 hours. After two weeks of no response to messages from staff clients will be discharged from the program or service will be on hold.
6. **Flexibility and Understanding:** We recognize that there may be exceptional circumstances, and we strive to approach each situation with flexibility and understanding. Open communication is encouraged to address any concerns or challenges regarding the cancellation policy.

By engaging in our services, clients acknowledge their understanding and agreement with the client exceptions and cancellation policy. We appreciate your cooperation and commitment to building a positive and effective relationship.

_____/_____/_____
Client Signature Date

_____/_____/_____
PDS Staff Signature Date