# Spectrum Care LLC

An intake is used to review and verify that the service recipient record is maintained according to the licensing requirements in Minn Stat 245I and associated rules.

## ARMHS Recipient Record - Recipient Intake

**Person Information**

| | | |
|---|---|---|
| First name: | Last name: | |
| Date of Birth: | Email: | |
| Address: | Phone number: | Preferred language: |

**Intake Information**

| | |
|---|---|
| Date of Admission/Intake: | |
| Source of Referral (Name, Address, Phone Number): | |

**Living Arrangement**

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

**Emergency contact information #1**

| | |
|---|---|
| First name | Last name: |
| Phone number: | Email: |

**Emergency contact information #2**

| | |
|---|---|
| First name | Last name: |
| Phone number: | Email: |

**Health care provider contact information (if applicable)**

| | |
|---|---|
| Primary physician or medical provider name: | |
| Phone number: | Fax number and/or email: |

| |
|---|
| Case Manager name: |

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| Phone number: | Fax number and/or email: |
|---|---|

| Therapist name: | |
|---|---|
| Phone number: | Fax number and/or email: |

### Family, Friends or other supports (if applicable) for coordination

**Contact information #1**

| First name | Last name: |
|---|---|
| Phone number: | Email: |

**Contact information #2**

| First name | Last name: |
|---|---|
| Phone number: | Email: |

1. **Specific needs of the client** including (1) developmental status, (2) cognitive functioning, and (3) physical and mental abilities (Minn. Stat. §245I.09 subd. 3)

| (1) developmental status | |
|---|---|
| (2) cognitive functioning | |

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| | |
|---|---|
| (3) physical and mental abilities | |
| (4) Other Significant medical and health-related needs | |

**2. Required Documentation Completed in Recipient Record**

| Required Documentation Completed in Recipient Record | Document Title | Staff Initials | Date Reviewed or Completed |
|---|---|---|---|
| Client rights and protections:<br>1) Policy on right to be free from discrimination<br>2) Policy on right to be informed of a photograph<br>3) Rights in the Health Care Bill of Rights | 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 (626.557) | Maltreatment of Vulnerable Adults Mandated Reporting | | |
| Maltreatment of Minors (260E) | Maltreatment of Minors Mandated Reporting | | |

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| | | | |
|---|---|---|---|
| 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 | N/A | N/A |
| Consents for releases of information as applicable (other healthcare providers, caregivers, case managers, etc) | "FORM - Minnesota Standard Consent form to release health information" | | |
| (If applicable) Date of the client's discharge, reason discontinued services for the client, and the client's discharge summaries. | FORM - Discharge summary form | | |

**3. Written information by the client that the client requests to include in the client's file**

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**4. Records of Communications Regarding Client**

*Record of each communication that a staff person has with the client's other mental health providers and persons interested in the client, including the client's case manager, family members, primary caregiver, legal representatives, court representatives, representatives from the correctional system, or school administration

| Date of Communication | Who Communicated? | Summary/Comments |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**5. Crisis and Relapse Prevention Plan**

**Client Name:**_____

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:

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

5. Current pressures or stressors in my life are:

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. Name: Phone number:
   b. Name: Phone number:
   c. Name: Phone number:
   d. Name: Phone number:

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

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

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:

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:

- Location has high crime rate
- Confidentiality could be breached at the location (next to other people)
- Likelihood of exposure to COVID or other infectious disease
- Other: _____
- Other: _____
- Other: _____
- Other: _____

**And our plan to address the items above is:**

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

Area Mental Health Crisis Response Phone numbers:
Anoka: 763-755-3801, Blue Earth County: 877-399-3040, Carver/Scott:952-442-7601, Dakota: 952-891-7171, Hennepin: 612-596-1223, Olmsted: 1-844-274-7472, Ramsey: 651-266-7900, Sherburne: 800-635-8008, Stearns: 800-635-8008, & Washington:651-777-5222
National Crisis/LifeLine (Call or Text): 988

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

| Name | Sign;ature | Title | Date |
|---|---|---|---|
| | | Recipient | |
| | | Participant's Caregiver | |
| | | Staff Member | |
| | | | |
| | | | |