

Dakota County Mental Health Resource Guide

Local Resources

Dakota County, the Local Mental Health Authority, identifies the following primary local mental health, health and human services resources.

The resource list for Dakota County includes the following:

- Dakota County Social Services
1 Mendota Rd. W., W. St. Paul
 - Adult Services Intake**
Bill Coleman: 651-554-6438
 - Rule 79 Case Management**
Tom Maki: 651-554-6343
 - Chemical Health**
Emily Schug: 651-554-6316
- Dakota County Crisis Response
14955 Galaxie Ave, Apple Valley
 - Crisis Response Unit**
Brian McGlenn: 952-891-7455
- Mental Health Resources
 - Rule 79 Case Management**
Ann Henderson: 651-365-3588
- People Incorporated
 - Rule 79 Case Management**
Jodie Brend: 952-431-6611
- Dakota County Public Health
1 Mendota Rd. W., W. St. Paul
 - Public Health**
Nancy Jurgensen: 651-554-6104
- Associated Clinic of Psychology
6950 W. 146th St. #100, Apple Valley
 - Outpatient Mental Health Services**
John Brose: 612-925-6033
- Dakota County CDA
 - Housing Subsidies**
Deborah Haugh: 651-675-4530
- Minnesota Rehabilitation Services
1 Mendota Rd W, Ste 170, W. St. Paul
 - Rehabilitation Services**
Chris McVey: 651-554-6560
- Guild Inc. CSP
1740 Livingston Av., W. St. Paul
 - Rule 79 Case Management & CSP**
Richard Alyward: 651-291-0067 x 480

- *Guild CSP has a center-based program in addition to community CSP services. The ARMHS applicant will be expected to offer this program for services not covered in the ARMHS benefit as a resource to those ARMHS clients who are in their geographic area.*

**ADULT REHABILITATIVE MENTAL HEALTH SERVICES (ARMHS)
DAKOTA COUNTY LOCAL RECERTIFICATION APPLICATION**

Provider Entity Legal Name: _____

Provider Entity Main Corporate Address: _____
Street Address

City, State, Zip

Type of Organization (check one):

Governmental Unit For Profit Non Profit Partnership

Proprietorship Federal Tax I.D. # _____

Names, Titles, Addresses of Organization Officers:

Name Address

Title City, State, Zip

Name Address

Title City, State, Zip

Name Address

Title City, State, Zip

Provider Entity Dakota County Services Address:

Contact Person Name & Title: _____
(for certification purposes)

Contact Person Address: _____
Street Address

City, State, Zip

Contact Person Phone Number: _____

Contact Person Fax Number: _____

Contact Person E-mail Address: _____

Purpose of Local Certification:

Legislative language related to Adult Rehabilitative Mental Health Services states, "If an entity seeks to provide services outside its host county, it must obtain additional certification from each county in which it will provide services. The additional certification must be based on the adequacy of the entity's knowledge of that county's local health and human service system, and the ability of the entity to coordinate it services with the other services available in that county."

In line with the above stated purpose, as a provider entity seeking Dakota County Local Certification our agency, _____ agree to the following:
(Name of Provider Agency)

1. Our agency assures that agency staff who provide direct service and who supervise direct service staff will, within six weeks of starting work with our agency, receive training about Dakota County's health and human services system. The "Dakota County Mental Health Resource Guide" and the "Critical Resources Phone Listing" will be included in this training. These and other resources identified by our agency will be available for staff reference and updated as needed.
2. Our agency assures it will work with Dakota County as needed to assure overall coordination of the service system.
3. With regard to service coordination for specific clients:
 - A. Our agency assures that agency staff who provide direct service and who supervise direct service staff will, within six weeks of starting work with our agency, receive training about how to coordinate services with family, persons identified by a client as significant in their life and other providers of services.
 - B. Further, as permitted by each client through completion of a release of information, our agency assures it will provide evidence of its efforts to coordinate the development of treatment plans with family members, others identified as significant in the life of a client and other service providers, including a client's case manager, by documenting these efforts and involvement of these parties in treatment plan development.
 - C. In addition, as permitted by each client through completion of a release of information, our agency assures it will provide evidence of its efforts to notify family, others significant in the life of a client and other service providers, of significant events and/or changes with a client, by documenting these efforts in client progress notes.
 - D. Finally, as permitted by each client through completion of a release of information, our agency assures it will provide evidence of its timely responses to family, others significant in the life of a client and other service providers, by documenting these efforts in client progress notes.

Signature

Date

Print Name

Title

Agency

Address