LEHIGH/NORTHAMPTON COUNTIES CASE MANAGEMENT AND/OR CERTIFIED PEER SPECIALIST REFERRAL APPLICATION FORM

A psychiatric/psychological evaluation completed within the last six months or recent treatment notes *including current diagnosis* must accompany this referral along with a current medication list. If the referral is not complete or if the evaluation is outdated, it may be returned to you.

Section I: Demographic Information

Date of Referral:	**SSN:**		**Preferred Language:** ☐ English ☐ Spanish ☐ Other:
Applicant's Name:		**Gender:**	
Address (if homeless, last known address):			
Primary Phone:	**Ok to leave a voice mail? YES ☐ NO ☐**		**DOB & Age:**
Alternate Phone:	**Ok to leave a voice mail? YES ☐ NO ☐**		**Email:**
Emergency Contact/Guardian:		**Phone#:**	**Email:**

Providers: Please check the provider you are sending this referral to. Please pick only one provider.

Please Note: For referrals to TIP (Transition to Independence) contact 215-317-9939 ☐ **Conference of Churches: BCM** **Fax: 484-664-7322 Phone: 484-664-7320** ☐ **Lehigh Valley ACT: BCM** **Fax: 610-882-3181 Phone: 610-882-1355** ☐ **Lehigh County MH/ID: BCM** **Fax: 610-871-1455 Phone: 610-781-3151** ☐ **Northampton County MH: BCM/ICM** **Fax: 610-997-5837 Phone: 610-829-4819**	☐ **Pennsylvania Mentor:** ☐ **ICM** ☐ **RC** ☐ **CPS (check one)** **Fax: 610-867-2695 Phone: 610-867-3173** ☐ **NHS:** ☐ **BCM** ☐ **CPS (check one)** **Fax: 610-866-8408 Phone: 610-866-8331** ☐ **Holcomb Behavioral Health: ICM** **Fax: 610-330-2853 Phone: 610-330-9862 (Easton)** **Fax: 610-435-3044 Phone: 610-435-4151 (Allentown)**	☐ **Salisbury Behavioral Health:** ☐ **BCM** ☐ **CPS (check one)** **Fax: 610-391-1682 Phone: 610-973-0971** ☐ **Recovery Partnership: CPS** **Fax: 610-861-2781 Phone: 610-861-2741** **(Reflections 24 hour Peer Support may also be contacted at the above number)** ☐ **PeerStar, LLC** ☐ **Forensic Peer** ☐**CPS (check one)** **Fax: 484-574-8951 Phone: 484-574-8912**

** For individuals without Magellan please fax the referral to the county of residence listed above.*

Section II: *To be completed by Referral Source*:

Referred by:		**Title/Position:**	
Agency:		**Phone/Email:**	

Reason for Referral (How would this person benefit from Targeted Case Management or a Certified Peer Specialist):

Current needs or service gaps(check any that apply): ☐Homelessness ☐MH Treatment Provider ☐Primary Care Physician Provider ☐Social Security Benefits☐ Insurance ☐ Vocational/Educational Supports ☐ Drug and/or Alcohol Treatment ☐ Other (specify):

If homeless please specify current living situation: ☐ Non-housing (street, park, car, etc.) ☐ Living w/ relatives or friends ☐ Emergency Shelter ☐ Other (specify):

Has the referral been discussed with the individual? ☐ Yes ☐ No

Any history of the following? ☐ Trauma ☐ Suicidal thoughts/attempts ☐ Homicidal thoughts/actions ☐ Fire setting ☐ Aggressive/assaultive behavior ☐ Are there any weapons in the home? Please explain if any are checked:

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Section III: Insurance/Funding Source and Income:

Type of Insurance:	Member ID #:	Income Source:	Monthly Amount:
Medical Assistance		**Employment:**	
Medicare		**SSI/SSDI:**	
County Funded: ☐ **Lehigh** ☐ **Northampton**	**BSU #:**	**Other Income:**	

Section IV: Eligibility Criteria for BCM/ICM/RC and CPS Services:

Diagnosis – The individual being referred must have a diagnosis within DSM V excluding those with a principal diagnosis of intellectual disability, psychoactive substance abuse, organic brain syndrome or a V-Code.

Mental Health DSM V Diagnoses:	**Physical Health Diagnoses:**

Psychosocial Stressors:

Criteria For BCM/ICM/RC - Treatment History – check all that apply (must meet one or more):

☐	6 or more days of psychiatric inpatient treatment in the past 12 months
☐	Met standards for involuntary treatment within the past 12 months
☐	Currently receiving or in need of 2 or more human service agencies/public systems (D&A, OVR, Crim Just, etc.)
☐	At least 3 missed community MH appointments within the past 12 months
☐	2 or more face to face encounters with crisis/emergency services within the past 12 months
☐	Documentation of inability to maintain medication regime for a period of at least 30 days

Criteria for CPS – Functional Impairment - Difficulties that substantially interfere with or limit (must meet one or more):

☐	A person from achieving or maintaining one or more developmentally-appropriate social, behavioral, cognitive, communicative, or adaptive skills
☐	Role functioning in one or more major life activities including basic daily living skills (e.g., eating, bathing, dressing)
☐	Instrumental living skills (e.g. maintaining a household, managing money, getting around the community, taking prescribed medication)
☐	Functioning in social, family, and vocational/educational contexts

Please Note: If referral is for Certified Peer Specialist; a recommendation must be signed below by a Practitioner of the Healing Arts, consisting of either a physician, licensed psychologist, certified registered nurse practitioner, or physician's assistant. The Individual being referred to CPS services must also sign below.

Signature of Licensed Practitioner of the Healing Arts	**Date**
Printed Name:	**Phone number:**
Address:	
Individuals Signature	**Date**