LEHIGH/NORTHAMPTON COUNTIES CASE MANAGEMENTAND/OR CERTIFIED PEER SPECIALIST REFERRAL APPLICATION FORM - ADULT

Section I: Demographic Information. ***To be completed by the individual.***

Date of Referral:	SSN:	Preferred Language:
Applicant's Name:	Gender Identity:	Assigned Sex at Birth:
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:

Does this individual need help applying for Social Security benefits? If so, please refer to a SOAR identified Case Management Provider. SOAR is a national program for those who are experiencing or at risk of homelessness and have a serious mental illness, medical impairment, and/or a co-occurring substance use disorder. (more information about SOAR is here: https://soarworks.samhsa.gov/).

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

Access TIP (Transition to Independence): ICM
Email: TIP@accessservices.org
Phone: 215-317-9939

Conference of Churches (SOAR): BCM *(Spanish Speaking)*
Fax: 484-664-7322 **Phone**: 484-664-7320

Lehigh Valley ACT: BCM
Fax: 610-882-3181 **Phone**: 610-882-1355

Lehigh County MH/ID (SOAR): BCM
Only non-Magellan referrals
Fax: 610-871-1455 **Phone**: 610-782-3151

Northampton County MH (**SOAR**): BCM/ICM
Fax: 610-974-7596 **Phone**: 610-829-4819

Pennsylvania Mentor
ICM RC CPS (check one)
Fax: 610-867-2695 **Phone**: 610-867-3173

Merakey *(Spanish speaking)*
BCM CPS (check one)
Fax: 610-866-8408 **Phone**: 610-866-8331

Chimes Holcomb Behavioral Health (SOAR): ICM *(Spanish Speaking)* Referral Contact: Emily Shosh
Easton: **Fax**: 610-330-2853
Phone: 610-330-9862
Allentown: **Fax**: 610-435-3044
Phone: 610-435-4151

RHA Health Services (SOAR):
BCM CPS (check one)
Fax: 610-391-1682 **Phone**: 610-973-0971

Recovery Partnership: CPS
Fax: 610-861-2781 **Phone**: 610-861-2741
*Also provides 24/7 Peer Support

Peerstar, LLC:
Forensic Peer CPS (check one)
Fax: 484-574-8951 **Phone**: 484-574-8912

Valley Youth House: CPS (ages 14-26)
Fax and **Phone**: 610-820-0166

Omni Health Services: CPS
Fax: 484-221-8318 **Phone**: 484-221-8296

**** 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 Case Management or a Certified Peer Specialist):

Housing/living situation
Please specify:
Living with relatives or friends.
Non-housing (street, park, car, etc.)
Emergency Shelter
Other (Please specify):
_____
Activities of daily living (Bathing, dressing, etc.)
Childcare
Criminal Justice

Drug and alcohol treatment
Education/Vocational training & supports
Finding, getting, or keeping a job
Food
Getting or maintaining benefits
Help with medical bills
Legal issues (not criminal)
Managing money or budget help
Mental Health treatment provider
Primary Care Physician/provider

Safety
Social activities
Social Security Benefits
System Navigation
Transportation advice or options
Understanding my health needs
Utilities
Other: _____

Is there any history of the following: Trauma Suicidal thoughts/attempts Homicidal thoughts/actions Fire Setting Property Destruction Aggressive/assaultive behavior Weapons in the home. **Please explain all checked items:**

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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 (with codes):	**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

Section V: Attachments

Please select AND attach the following:
Proof of Diagnosis: Psychiatric evaluation within the past 6 months **OR** Recent treatment notes and documentation of Mental Health diagnoses. Individual will need assistance scheduling a psychiatric evaluation.
Complete list of current medications.

*Please Note: If this referral is for Certified Peer Specialist; a recommendation must be signed below by a Practitioner of the Healing Arts consisting of either a Physician, Physician's Assistant, Certified Registered Nurse Practitioner, Licensed Psychologist, Licensed Clinical Social Worker, Licensed Professional Counselor, or Licensed Marriage, and Family Therapist. The Individual being referred to CPS services must also sign below.

Signature AND credentials of Licensed Practitioner of the Healing Arts:	**Date:**
Printed Name:	**Phone:**
Address:	

Individual's Signature:	**Date:**