

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

Section I: Demographic Information. To be completed by the individual if 14+

Date of Referral:	Child/Youth's Name:	DOB & Age:	
SSN:	Preferred Language:	Gender Identity:	Assigned Sex at Birth:
Address (if homeless, last known address):			
Primary Contact's Phone:	Ok to leave a voice mail? <input type="checkbox"/> Yes <input type="checkbox"/> No	Primacy Contact's Email:	
Currently enrolled in school: <input type="checkbox"/> Yes <input type="checkbox"/> No	School:		
Grade: _____ IEP: <input type="checkbox"/> Yes <input type="checkbox"/> No	School Contact:		
Parent/Guardian/Emergency Contact:	Phone:	Email:	
Address: <input type="checkbox"/> Same as above			

Providers: Please check the provider you are sending this referral to. Please pick only one provider.	
<input type="checkbox"/> Pennsylvania Mentor <input type="checkbox"/> ICM <input type="checkbox"/> RC (check one) Fax: 610-867-2695 Phone: 610-867-3173 <input type="checkbox"/> RHA Health Services: BCM Fax: 610-391-1682 Phone: 610-973-0971 <input type="checkbox"/> Access TIP (Transition to Independence): ICM Email: TIP@accessservices.org Phone: 215-317-9939	<input type="checkbox"/> Chimes Holcomb Behavioral Health: 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 <input type="checkbox"/> Nulton Diagnostic & Treatment Center: BCM Fax: 610-391-1682 Phone: 610-224-9311 <input type="checkbox"/> Valley Youth House: CPS (Ages 14-26) Fax and Phone: 610-820-0166

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):

<input type="checkbox"/> Housing/living situation Please specify: <input type="checkbox"/> Living with relatives or friends. <input type="checkbox"/> Non-housing (street, park, car, etc.) <input type="checkbox"/> Emergency Shelter <input type="checkbox"/> Other (Please specify): _____ <input type="checkbox"/> Activities of daily living (Bathing, dressing, etc.) <input type="checkbox"/> Childcare <input type="checkbox"/> Criminal Justice	<input type="checkbox"/> Drug and alcohol treatment <input type="checkbox"/> Education/Vocational training & supports <input type="checkbox"/> Finding, getting, or keeping a job <input type="checkbox"/> Food <input type="checkbox"/> Getting or maintaining benefits <input type="checkbox"/> Help with medical bills <input type="checkbox"/> Legal issues (not criminal) <input type="checkbox"/> Managing money or budget help <input type="checkbox"/> Mental Health treatment provider	<input type="checkbox"/> Primary Care Physician/provider <input type="checkbox"/> Safety <input type="checkbox"/> Social activities <input type="checkbox"/> Social Security Benefits <input type="checkbox"/> System Navigation <input type="checkbox"/> Transportation advice or options <input type="checkbox"/> Understanding my health needs <input type="checkbox"/> Utilities <input type="checkbox"/> Other: _____
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Section III: Risk Assessment

Is the child/youth at **CURRENT** risk or do they have a history of:

Risk/Behavior	Current Risk		Describe	History		Describe
	Yes	No		Yes	No	
Trauma						
Suicidality						
Homicidal						
Violence						
Fire setting						
Property destruction						
Aggressive/Assaultive Behaviors						
Is the child/youth able to contract for safety?						<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the child/youth compliant with their medication regime?						<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Are there any weapons in the home?						<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the child/youth have legal charges pending?						<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the child/youth currently using drugs and/or alcohol?						<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please describe:						

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

Diagnosis – The individual being referred <u>must</u> 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:

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. Child/Youth will need assistance scheduling a psychiatric evaluation.
- Complete list of current medications.

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

Individual's Signature if 14+:	Date: