

Lehigh County Step By Step and Transitional Living Center (TLC) Referral Form

Please check ONE residential level of care:

Full-Care CRR * – Step By Step and TLC – 24 hr. staff
(check skills as needed below)

Moderate-Care CRR * – TLC – 10 hr. staff
(check skills as needed below)

Fairweather Lodge – Step By Step – minimal staff, manage own medications, must be drug & alcohol free for at least 1 year prior to application date, must be employed 20 hrs. / wk.
(check skills as needed below)

Date of Referral: _____

Referral Source: _____

Name: _____

Agency: _____

Address: _____

Phone: _____

Email: _____

Life Skills Needed – UTILIZE ONLY FOR SERVICES ABOVE:

- | | |
|----------------------------|---------------------------------|
| Budgeting | Medications |
| Cooking / Nutrition | Money Management |
| Daily Structure | Personal Hygiene |
| Housekeeping | Public Trans / Mobility |
| Interpersonal | Safety Awareness |
| Leisure Activities | Shopping |
| Managing Time | Vocational / Educational |

STRIDE – Step By Step Weil Street – 40 hrs. / wk. staff, must have income, manage own medications, must be drug & alcohol free for at least a year prior to application date

Independent Apartments – Step By Step Congress and Woodward – no staff & unfurnished, must have income, must be drug & alcohol free for at least 1 year prior to application date

PLEASE NOTE:

*** Full Care and Moderate Care levels are transitional with average lengths of stay being 6-9 months.**

Name: _____

Current Address: _____

Current Living Environment: _____

Current Phone: _____

Date of Birth: _____ **SSN:** _____

Marital Status: _____ **Gender:** _____

Education (highest grade completed): _____

Emergency Contact: _____

Relationship: _____

Address: _____

Phone: _____

Monthly Income: _____ **Source(s):** _____

(Select only one) BCM ACT Case Manager

Name: _____

Agency: _____

Community Psychiatrist: _____

Location: _____

Phone: _____

Diagnoses:

Primary Dx: _____

ICD-10 Code#: _____ - _____

Secondary Dx: _____

ICD-10 Code#: _____ - _____

Current Day Programming (i.e. – employment, school, volunteering, PHP, psych rehab, clubhouse, etc.):

LEHIGH COUNTY Magellan: YES NO
Medicare: Yes - A B D NO

Outstanding medical conditions / physical limitations:

Other Insurance: _____

Representative Payee: _____

Phone: _____

Family Physician: _____

Phone: _____

Legal Charges (past and present): _____

Probation / Parole Officer Name: _____ **Phone:** _____

Drug and Alcohol History / Current Treatment: _____

DATE OF MOST RECENT USE: _____

Suicidal Behavior / Attempts: _____

History of Violence: _____

Symptomology: _____

Fire Setting History: _____

Past Agency / Hospital / Treatment Involvement:

Hospital / Agency / Treatment Facility Name:

Dates:

REASON FOR REFERRAL... PLEASE DESCRIBE DETAIL OF NEEDS BASED ON LEVEL OF CARE CHOSEN:

PLEASE ALSO PROVIDE THE FOLLOWING:

A Psychiatric Evaluation with in the last 12 months, **OR** an older Psychiatric Evaluation with recent treatment notes including current diagnosis.

ALL REFERRALS NEED TO BE FORWARDED TO LEHIGH COUNTY FOR REVIEW:

Lehigh County MH/ID/D&A
Attn: CRR / Housing Liaison
17 S 7th Street
Allentown PA 18101
FAX#: 610-820-3689 OR 610-871-1455

CRR/LODGE/INDEPENDENT APT. REFERRALS NEED TO BE FORWARDED TO THE APPROPRIATE AGENCY:

Step By Step
Attn: Intake Personnel
623 W Union Blvd
Bethlehem PA 18018
FAX#: 610-882-2497

Transitional Living Center
Attn: Intake Personnel
264A Levan St
Allentown PA 18102
FAX#: 610-841-5324