

Lehigh County Residential Programs Referral Form

In an effort to be environmentally friendly, referrals to the long term residential programs listed below will be screened and then forwarded to the appropriate agency by Lehigh County.

Please check ONE residential level of care:

Date of Referral: _____

- Resource for Human Development** – Community Residential Rehabilitation - Hope Springs
- Merakey** – Enhanced Personal Care Home
- Merakey** – Enhanced Community Residential Rehabilitation
- Salisbury Behavioral Health** – Enhanced Personal Care Home – Acorn
- Salisbury Behavioral Health** – Supported Housing
- Step By Step** – Long Term Structured Residence – Forensic
- Step By Step** – W Congress Supported Housing – Forensic
- Step By Step** - Enhanced Community Residential Rehabilitation

Referral Source:

Name: _____

Agency: _____

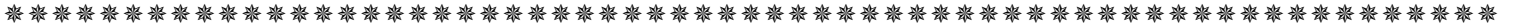
Address: _____

Phone: _____

Email: _____

Life Skills Needed

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



Name: _____

(Select only one) BCM ACT Case Manager

Current Address: _____

Name: _____

Agency: _____

Current Living Environment: _____

Community Psychiatrist: _____

Current Phone: _____

Location: _____

Date of Birth: _____ SSN: _____ - _____ - _____

Phone: _____

Marital Status: _____ Gender: _____

Education (highest grade completed): _____

Diagnoses:

Emergency Contact: _____

Primary Dx: _____

Relationship: _____

ICD-10 Code#: _____ - _____

Address: _____

Secondary Dx: _____

Phone: _____

ICD-10 Code#: _____ - _____

Monthly Income: _____ Source(s): _____

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

Representative Payee: _____

Phone: _____

LEHIGH COUNTY Magellan: YES NO

Outstanding medical conditions / physical limitations:

Medicare: Yes - A B D NO

Other Insurance: _____

Family Physician: _____ **Phone:** _____

Legal Charges (past and present): _____

If currently incarcerated: current and past misconducts/segregation: _____

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 & Address:

Dates:

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

PLEASE ALSO PROVIDE THE FOLLOWING:

A Psychiatric Evaluation within the las 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