Magellan Behavioral Health of Pennsylvania, Inc.

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

SECTION I: Demographic Information – *to be completed by the individual.*

Date of Referral: _____ Social Security Number: _____ Preferred Language: _____

Applicant Name: _____ Gender Identity: _____ Assigned Sex at Birth: _____

Address: (if homeless, last known address) _____

Primary phone #: _____ Okay to leave a voicemail message: ☐ Yes ☐ No Date of birth: _____

Alternate phone #: _____ Okay to leave a voicemail message: ☐ Yes ☐ No Age: _____

Emergency Contact / Guardian: _____

☐ **SOAR:** Does this individual need help applying for social security benefits? If so, please refer to a SOAR identified Case Management Provider.

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

☐ Access Services TIP Program (Transition to Independence) BCM	Email: TIP@accessservices.org	Phone: 484-866-8781
☐ Conference of Churches (SOAR) BCM *(Spanish speaking)*	Fax: 484-664-7322	Phone: 484-664-7320
☐ Lehigh County MH/ID (SOAR) BCM *(Only non-Magellan referrals)*	Fax: 610-871-1455	Phone: 610-782-3151
☐ Northampton Co MH (SOAR) BCM/ICM *(Only non-Magellan referrals)*	Fax: 610-974-7596	Phone: 610-829-4819
☐ Nulton Diagnostic BCM	Fax: 814-266-2880	Phone: 610-224-9311
☐ Pennsylvania Mentor ☐ ICM ☐ RC ☐ CPS	Fax: 610-867-2695	Phone: 610-867-3173
☐ Merakey *(Spanish speaking BCM)* ☐ BCM ☐ CPS	Fax: 610-866-8408	Phone: 610-866-8331
☐ RHA Health Services (SOAR) ☐ BCM ☐ CPS	Fax: 610-391-1682	Phone: 610-973-0971
☐ Recovery Partnership CPS *(also provides 24/7 Peer Support)*	Fax: 610-861-2781	Phone: 610-861-2741
☐ PeerStar LLC ☐ Forensic Peer ☐ CPS	Fax: 484-574-8951	Phone: 484-574-8912
☐ Valley Youth House CPS *(ages 14-26)*	Fax: 267-423-4340	Phone: 267-423-4340
☐ Omni Health Services CPS	Fax: 484-221-8318	Phone: 484-221-8296
Chimes Holcomb Behavioral Health (SOAR) ICM *(Spanish Speaking)*		
☐ Easton Location *(Referral contact: Emily Shosh)*	Fax: 610-330-2853	Phone: 610-330-9862
☐ Allentown Location *(Referral contact: Emily Shosh)*	Fax: 610-435-3044	Phone: 610-435-4151

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

SECTION II: T*o 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?

☐ Activities of daily living *(i.e. bathing)*	☐ Childcare	☐ Criminal Justice
☐ Drug and alcohol treatment	☐ Educational / Vocational training	☐ 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 _____

Housing / Living Situation – Please specify:

☐ Living w/ relatives or friends ☐ Non-housing *(street, park, car, etc.)* ☐ Emergency Shelter ☐ Other: _____

Is there any history of the following:

☐ Aggressive / Assaultive Behavior ☐ Suicidal Thoughts / Attempts ☐ Homicidal Thoughts / Actions

☐ Trauma ☐ Fire Setting ☐ Property Destruction ☐ Weapons in the home

Please explain all checked items: _____

SECTION III: Insurance/Funding Source and Income:

Type of Insurance	Member ID #	Income Source:	Monthly Amount:
Medical Assistance	_____	Employment:	_____
Medicare	_____	SSI/SDSDI:	_____
County Funded:	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 six months, **OR**

☐ Recent treatment notes and documentation of Mental Health diagnoses. Individual will need assistance scheduling a psychiatric evaluation, **AND**

☐ 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: _____

Address: _____ Phone: _____

Individual's Signature _____ Date: _____