

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 or 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 meds, must work 15 hrs./wk. – or – see day programming
(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 |

Independent Apartments – Step By Step Congress and
Woodward – no staff, must have income, unfurnished

PLEASE NOTE: *INDIVIDUALS REFERRED FOR THE FAIRWEATHER LODGE NEED TO BE GAINFULLY EMPLOYED AT LEAST 15 HRS. / WK.; OR RECEIVING OTHER LEGITIMATE INCOME AND BE WORKING, VOLUNTEERING, OR ENROLLED IN SCHOOL.

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

Name: _____

County Mental Health Case#: _____

Current Address: _____

BCM/ACT/Case Manager: _____
(Circle One Only)

Community Psychiatrist: _____

Current Living Environment: _____

Location: _____

Current Phone: _____

Phone: _____

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

Diagnoses:

Marital Status: _____ **Gender:** _____

Primary Dx: _____

Education (highest grade completed): _____

ICD-10 Code#: _____ - _____

Emergency Contact: _____

Secondary Dx: _____

Relationship: _____

ICD-10 Code#: _____ - _____

Address: _____

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

Phone: _____

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

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:

- Most recent **Psychiatric Evaluation**, and/or Clinical/Treatment notes from the Psychiatric Provider which includes the current diagnoses – **MUST BE** dated from within the past 12 months.

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:

- | | |
|---|--|
| <input type="checkbox"/> Step By Step
Attn: Intake Personnel
623 W Union Blvd
Bethlehem PA 18018
FAX#: 610-882-2497 | <input type="checkbox"/> Transitional Living Center
Attn: Intake Personnel
264A Levan St
Allentown PA 18102
FAX#: 610-841-5324 |
|---|--|