

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:

- AIR Horizon House** – All Inclusive Residential – Trestle House
- AIR RHD** – All-Inclusive Residential – Hope Springs
- Horizon House SAL**–Supervised Apartment Living – The SHORE
- NHS** – Enhanced Personal Care Home
- SBH** – Enhanced Personal Care Home – Acorn
- SBH** – Supported Housing

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 |

Name: _____

County Mental Health Case#: _____

Current Address: _____

ICM/ACT/Case Manager: _____

Community Psychiatrist: _____

Current Living Environment: _____

Location: _____

Current Phone: _____

Phone: _____

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

Diagnoses:

Marital Status: _____ **Gender:** _____

Primary Dx: _____

Education (highest grade completed): _____

DSM-5 Code#: _____ - _____

Emergency Contact: _____

Secondary Dx: _____

Relationship: _____

DSM-5 Code#: _____ - _____

Address: _____

Tertiary Dx: _____

Phone: _____

DSM-5 Code#: _____ - _____

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

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

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