

**LEHIGH/NORTHAMPTON COUNTIES CASE MANAGEMENT AND/OR
CERTIFIED PEER SPECIALIST REFERRAL APPLICATION FORM**

A psychiatric/psychological evaluation completed within the last six months or recent treatment notes *including current diagnosis* must accompany this referral along with a current medication list. If the referral is not complete or if the evaluation is outdated, it may be returned to you.

Section I: Demographic Information

Date of Referral:	SSN:	Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish
Applicant's Name:	Gender:	<input type="checkbox"/> Other:
Address (if homeless, last known address):		
Primary Phone:	Ok to leave a voice mail? YES <input type="checkbox"/> NO <input type="checkbox"/>	DOB & Age:
Alternate Phone:	Ok to leave a voice mail? YES <input type="checkbox"/> NO <input type="checkbox"/>	Email:
Emergency Contact/Guardian:	Phone#:	Email:

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

<p><i>*Please Note: For referrals to TIP (Transition to Independence) contact 215-317-9939</i></p> <p><input type="checkbox"/> Conference of Churches: BCM Fax: 484-664-7322 Phone: 484-664-7320</p> <p><input type="checkbox"/> Lehigh Valley ACT: BCM Fax: 610-882-3181 Phone: 610-882-1355</p> <p><input type="checkbox"/> Lehigh County MH/ID: BCM Fax: 610-871-1455 Phone: 610-781-3151</p> <p><input type="checkbox"/> Northampton County MH: BCM/ICM Fax: 610-997-5837 Phone: 610-829-4819</p>	<p><input type="checkbox"/> Pennsylvania Mentor: <input type="checkbox"/> ICM <input type="checkbox"/> RC <input type="checkbox"/> CPS (check one) Fax: 610-867-2695 Phone: 610-867-3173</p> <p><input type="checkbox"/> NHS: <input type="checkbox"/> BCM <input type="checkbox"/> CPS (check one) Fax: 610-866-8408 Phone: 610-866-8331</p> <p><input type="checkbox"/> Holcomb Behavioral Health: ICM Fax: 610-330-2853 Phone: 610-330-9862 (Easton)</p> <p>Fax: 610-435-3044 Phone: 610-435-4151 (Allentown)</p>	<p><input type="checkbox"/> Salisbury Behavioral Health: <input type="checkbox"/> BCM <input type="checkbox"/> CPS (check one) Fax: 610-391-1682 Phone: 610-973-0971</p> <p><input type="checkbox"/> Recovery Partnership: CPS Fax: 610-861-2781 Phone: 610-861-2741 (Reflections 24 hour Peer Support may also be contacted at the above number)</p> <p><input type="checkbox"/> PeerStar, LLC</p> <p><input type="checkbox"/> Forensic Peer <input type="checkbox"/> CPS (check one) Fax: 484-574-8951 Phone: 484-574-8912</p>
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** For individuals without Magellan please fax the referral to the county of residence listed above.*

Section II: To be completed by Referral Source:

Referred by:	Title/Position:
Agency:	Phone/Email:

Reason for Referral (How would this person benefit from Targeted Case Management or a Certified Peer Specialist):

<p>Current needs or service gaps(check any that apply): <input type="checkbox"/> Homelessness <input type="checkbox"/> MH Treatment Provider <input type="checkbox"/> Primary Care Physician Provider <input type="checkbox"/> Social Security Benefits <input type="checkbox"/> Insurance <input type="checkbox"/> Vocational/Educational Supports <input type="checkbox"/> Drug and/or Alcohol Treatment <input type="checkbox"/> Other (specify):</p>
<p>If homeless please specify current living situation: <input type="checkbox"/> Non-housing (street, park, car, etc.) <input type="checkbox"/> Living w/ relatives or friends <input type="checkbox"/> Emergency Shelter <input type="checkbox"/> Other (specify):</p>
<p>Has the referral been discussed with the individual? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Any history of the following? <input type="checkbox"/> Trauma <input type="checkbox"/> Suicidal thoughts/attempts <input type="checkbox"/> Homicidal thoughts/actions <input type="checkbox"/> Fire setting <input type="checkbox"/> Aggressive/assaultive behavior <input type="checkbox"/> Are there any weapons in the home? Please explain if any are checked:</p>

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Section III: Insurance/Funding Source and Income:

Type of Insurance:	Member ID #:	Income Source:	Monthly Amount:
Medical Assistance		Employment:	
Medicare		SSI/SSDI:	
County Funded: <input type="checkbox"/> Lehigh <input type="checkbox"/> Northampton	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:	Physical Health Diagnoses:

Psychosocial Stressors:

Criteria For BCM/ICM/RC - Treatment History – check all that apply (must meet one or more):

<input type="checkbox"/>	6 or more days of psychiatric inpatient treatment in the past 12 months
<input type="checkbox"/>	Met standards for involuntary treatment within the past 12 months
<input type="checkbox"/>	Currently receiving or in need of 2 or more human service agencies/public systems (D&A, OVR, Crim Just, etc.)
<input type="checkbox"/>	At least 3 missed community MH appointments within the past 12 months
<input type="checkbox"/>	2 or more face to face encounters with crisis/emergency services within the past 12 months
<input type="checkbox"/>	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):

<input type="checkbox"/>	A person from achieving or maintaining one or more developmentally-appropriate social, behavioral, cognitive, communicative, or adaptive skills
<input type="checkbox"/>	Role functioning in one or more major life activities including basic daily living skills (e.g., eating, bathing, dressing)
<input type="checkbox"/>	Instrumental living skills (e.g. maintaining a household, managing money, getting around the community, taking prescribed medication)
<input type="checkbox"/>	Functioning in social, family, and vocational/educational contexts

**Please Note: If referral is for Certified Peer Specialist; a recommendation must be signed below by a Practitioner of the Healing Arts, consisting of either a physician, licensed psychologist, certified registered nurse practitioner, or physician’s assistant. The Individual being referred to CPS services must also sign below.*

Signature of Licensed Practitioner of the Healing Arts	Date
Printed Name:	Phone number:
Address:	
Individuals Signature	Date