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)

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

Date of Referral: ______________________

Referral Source:

Name: ______________________

Agency: ______________________

Address: ______________________

____

Phone: ______________________

Email: ______________________

PLEASE NOTE: *INDIVIDUALS REFFERRED 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: ______________________

Current Address: ______________________

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Current Living Environment: ______________________

Current Phone: ______________________

Date of Birth: __________ SSN: __________

Marital Status: __________ Gender: __________

Education (highest grade completed): ______________________

Emergency Contact: ______________________

Relationship: ______________________

Address: ______________________

____

Phone: ______________________

Monthly Income: __________ Source(s): __________

__________ __________

County Mental Health Case#: ______________________

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

Community Psychiatrist: ______________________

Location: ______________________

Phone: ______________________

Diagnoses:

Primary Dx: ______________________

ICD-10 Code#: ______ - ______

Secondary Dx: ______________________

ICD-10 Code#: ______ - ______

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

____

____

____

LEHIGH COUNTY Magellan: ◯ YES ◯ NO
Medicare: Yes - ◯ A___ B___ D___ ◯ NO

Outstanding medical conditions / physical limitations: _____

Other Insurance: _____ _____

Representative Payee: _____ **Family Physician:** _____

Phone: _____ 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:

☐ **Step By Step**
Attn: Intake Personnel
623 W Union Blvd
Bethlehem PA 18018
FAX#: 610-882-2497

☐ **Transitional Living Center**
Attn: Intake Personnel
264A Levan St
Allentown PA 18102
FAX#: 610-841-5324