LEHIGH/NORTHAMPTON COUNTIES CASE MANAGEMENTAND/OR CERTIFIED PEER SPECIALIST REFERRAL APPLICATION FORM - ADULT

Section I: Demographic Information. ***To be completed by the individual.***

Date of Referral:	SSN:	Preferred Language:
Applicant's Name:	Gender Identity:	Assigned Sex at Birth:
Address (if homeless, last known address):		
Primary Phone:	Ok to leave a voice mail? YES ☐ NO ☐	DOB & Age:
Alternate Phone:	Ok to leave a voice mail? YES ☐ NO ☐	Email:
Emergency Contact/Guardian:	Phone#:	Email:

☐ **Does this individual need help applying for Social Security benefits? If so, please refer to a SOAR identified Case Management Provider.** SOAR is a national program for those who are experiencing or at risk of homelessness and have a serious mental illness, medical impairment, and/or a co-occurring substance use disorder. (more information about SOAR is here: https://soarworks.samhsa.gov/).

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

☐ Access TIP (Transition to Independence): ICM
Email: TIP@accessservices.org
Phone: 215-317-9939

☐ **Conference of Churches (SOAR):** BCM *(Spanish Speaking)*
Fax: 484-664-7322 **Phone**: 484-664-7320

☐ **Lehigh Valley ACT**: BCM
Fax: 610-882-3181 **Phone**: 610-882-1355

☐ **Lehigh County MH/ID (SOAR):** BCM
Only non-Magellan referrals
Fax: 610-871-1455 **Phone**: 610-782-3151

☐ **Northampton County MH** (**SOAR**): BCM/ICM
Fax: 610-974-7596 **Phone**: 610-829-4819

☐ **Pennsylvania Mentor**
☐ ICM ☐ RC ☐ CPS (check one)
Fax: 610-867-2695 **Phone**: 610-867-3173

☐ **Merakey** *(Spanish speaking)*
☐ BCM ☐ CPS (check one)
Fax: 610-866-8408 **Phone**: 610-866-8331

☐ **Chimes Holcomb Behavioral Health (SOAR):** ICM *(Spanish Speaking)* Referral Contact: Emily Shosh
Easton: **Fax**: 610-330-2853
Phone: 610-330-9862
Allentown: **Fax**: 610-435-3044
Phone: 610-435-4151

☐ **RHA Health Services** (SOAR):
☐ BCM ☐ CPS (check one)
Fax: 610-391-1682 **Phone**: 610-973-0971

☐ **Recovery Partnership**: CPS
Fax: 610-861-2781 **Phone**: 610-861-2741
*Also provides 24/7 Peer Support

☐ **Peerstar, LLC**:
☐ Forensic Peer ☐ CPS (check one)
Fax: 484-574-8951 **Phone**: 484-574-8912

☐ **Valley Youth House**: CPS (ages 14-26)
Fax and **Phone**: 610-820-0166

☐ Omni Health Services: CPS
Fax: 484-221-8318 **Phone**: 484-221-8296

**** 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 Case Management or a Certified Peer Specialist):

☐ Housing/living situation
Please specify:
☐ Living with relatives or friends.
☐ Non-housing (street, park, car, etc.)
☐ Emergency Shelter
☐ Other (Please specify):
_____
☐ Activities of daily living (Bathing, dressing, etc.)
☐ Childcare
☐ Criminal Justice

☐ Drug and alcohol treatment
☐ Education/Vocational training & supports
☐ 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: _____

Is there any history of the following: ☐ Trauma ☐ Suicidal thoughts/attempts ☐ Homicidal thoughts/actions ☐ Fire Setting ☐ Property Destruction ☐ Aggressive/assaultive behavior ☐ Weapons in the home. **Please explain all checked items:**

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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: ☐ Lehigh ☐ 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 (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 6 months **OR** ☐ Recent treatment notes and documentation of Mental Health diagnoses. Individual will need assistance scheduling a psychiatric evaluation.
☐ 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:	**Phone:**
Address:	

Individual's Signature	**Date**