REFERRAL FORM FOR ADOLESCENT BLENDED CASE MANAGEMENT

260 Ohio River Blvd. Baden, PA 15005

Please check all areas that apply

Date: _____ Individual's Name: _____ MA Number: _____

Individual's Address: _____ Individual's Phone Number: _____

Referring Agency: _____ Person Referring: _____ Referral Phone Number: _____

ADMISSION CRITERIA

Following are the eligibility requirements for Blended Case Management. Please complete this referral form completely, and attach most recent copy of psychiatric evaluation (ideally within past 12 months). Please fax this referral page and copy of most recent psychiatric evaluation to 724-869-2023 Attn: Blended Case Management.

Must Meet Criteria I, II and one or more of Criteria III

I. DIAGNOSIS

Diagnosis within DSM IV (or subsequent revisions), excluding those with a principal diagnosis of mental retardation, psychoactive substance abuse, organic brain syndrome or a V-code; COPY OF RECENT (WITHIN PAST 12 MONTHS OF DATE OF REFERRAL) PSYCHIATRIC/PSYCHOLOGICAL EVALUATION MUST BE ATTACHED TO THIS REFERRAL SHEET; **AND**

II. FUNCTIONING LEVEL

Global Assessment of Functioning Scale (as specified in the DSM IV-R or revisions thereafter) ratings of 70 or below; **AND**

III. INDICATORS OF CONTINUOUS HIGH SERVICE NEEDS: (Must have one of the following criteria)

___ a. Six or more days of psychiatric inpatient treatment in the past 12 months;

___ b. Without blended case management services would result in placement in a community inpatient unit, state mental hospital or other out-of-home placement, including foster homes or juvenile court placements;

___ c. Currently receiving or in need of mental health services and receiving or in need of services from two or more human service agencies or public systems such as Education, Child Welfare, Juvenile Justice, etc.

___ d. Currently receives Intensive Case Management or Resource Coordination Services.

EXCEPTION CRITERIA

Any individual who may benefit from blended case management services, but does not meet the requirements identified above may be eligible for blended case management services upon written prior approval by the Value Behavioral Health Managed Care Organization or Beaver County Behavioral Health, as applicable.

OUTSIDE AGENCIES

Agency Name: _____ Agency Phone: _____

Address: _____

_____

Please have individual sign Release of Information for your agency and fax with referral form to 724-869-2029, Attn BCM Supervisor

Individual Signature: _____ **Date:** _____

Clinician Signature: _____ **Date:** _____

☐ **Individual accepted into program** **Signature:** _____ **Date:** _____

☐ **Individual not accepted into program** **Signature:** _____ **Date:** _____

Contributing factors related to denial of admission at this time (if applicable):

Correspondence with referral source:

Merakey Staff_____ ***spoke to; emailed; faxed;*** **Referral Source Staff**_____ on **Date**_____

and informed the referral source that _____ ***was/was not*** admitted to the BCM program at this time.