

BEAVER COUNTY BEHAVIORAL HEALTH

1070 Eighth Avenue, Beaver Falls, PA 15010

Phone: 724-891-2827

Fax: 724-891-2865

CASE MANAGEMENT REFERRAL

DATE:	
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CONSUMER'S NAME:		FOR CHILD ONLY: PARENT/GUARDIAN		M.A. ID #:	
ADDRESS:				PHONE:	
SSN:		DOB:		AGE:	
INSURANCE:	VBH/Beacon	NONE	MA	OTHER:	

REASON FOR REFERRAL/NEED FOR SERVICE:

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REFERRING AGENCY:		REFERRING INDIVIDUAL:		PHONE:	
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DIAGNOSIS (Please list and attach a Psychiatric Evaluation Completed within the last 12 months)

1.		2.	
3.		4.	

ADULT TREATMENT HISTORY

# Days of psychiatric inpatient treatment in the last 12 months.		Check if 302/304 C Criteria were met in the last 12 months.	
Involved with or in need of any of the following services: Drug & Alcohol Vocational Rehabilitation Criminal Justice Other: _____		History of any of the following: At least 3 missed community mental health appointments in past 6 months Two or more face to face encounters with Crisis or Emergency services in the past 12 months Documentation that consumer has not maintained her/his medication regimen for at least 30 days Involuntary outpatient commitment.	

CHILD/ADOLESCENT TREATMENT HISTORY

# Days of psychiatric inpatient treatment in the last 12 months.		Check if at risk of out of home placement without BCM Services?	
Currently receiving or in need of services from 2 or more of the following Human service or public system agencies: ☐ Mental Health ☐ Child Welfare ☐ Other _____ ☐ Education ☐ Juvenile Justice		Check if recommended for MH services by CASSP or Multi-service Children's Team	

I agree to be contacted by BCBH to further discuss Case Management Services.

Consumer/Parent or Guardian Signature: _____ Date: _____

FOR BCBH USE ONLY

041:	Date Received:	CM:
DISPOSITION:	☐ Accepted ☐ Denied ☐ Withdrawn	PROGRAM: ☐ BCM ☐ ACM
Check if the individual is in need of BCM services as indicated through medical necessity criteria and in conjunction with clinical information and the professional judgment of the reviewer		
Reviewer/Supervisor:		Date Assigned: