TARGETED CASE MANAGEMENT PROGRAM REFERRAL

Please complete each section of this application. Please write not applicable (N/A) or unknown if a question does not apply or if the referral source does not know the information.

SECTION A: RELEASE/CONSENT FORM

Date: _____ Name: _____ DOB: _____

SS #: _____ Phone #: _____

Address: _____

Being referred to receive Targeted Case Management services in the following county:

Wicomico ☐ Worcester ☐ Somerset ☐

Referring Agency: _____

Agency Contact Person: _____ Phone#: _____

Fax #: _____ Email: _____

Please review and sign for Consent to Services *and* Information Release.

Consent to Services:

I understand that I am applying for case management services for the Targeted Case Management Program in the county indicated above. I agree to receive these services if approved and to participate in the development of a Service Plan, which I will be asked to sign. I understand that I may revoke my consent to services at any time by written or verbal request.

Consumer Signature (or Guardian): _____ Date: _____

Witness: _____ Date: _____

Information Release:

I authorize the above referenced referring provider to furnish to the Core Service Agency representing the county indicated above the information requested on the Targeted Case Management Program Referral for review. This information will used to make a pre-determination of eligibility for case management services. If found eligible for services, I further authorize the release of information to the Targeted Case Management program for full screening and service eligibility determination and to the Administrative Services Organization (ASO) to determine eligibility for Targeted Case Management services. I understand that I may revoke my permission at any time by written or verbal request.

Consumer Signature (or Guardian) _____ Date: _____

Witness: _____ Date: _____

Name: _____ DOB: _____ SS#: _____ Date: _____

SECTION B: DEMOGRAPHICS AND REQUIRED REPORTING DATA

1. **Please complete parent or guardian information if consumer being referred is a child or adolescent under the age of 18, or an adult with a legal guardian.**

Parent/Guardian #1	Parent/Guardian #2
First Name:	First Name:
Last Name:	Last Name:
Address:	Address:
Phone#:	Phone#:
Relationship to Consumer:	Relationship to Consumer:

2. **Please complete the following for *ALL* consumers (child or adolescent and adult referrals).**

Race
- ☐ White
- ☐ American Indian or Alaskan Native
- ☐ Black or African American
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander

Gender
- ☐ Male
- ☐ Female
- ☐ Transgender – Male to Female
- ☐ Transgender – Female to Male
- ☐ Other – please specify

Ethnicity
- ☐ Not Hispanic/Latino
- ☐ Hispanic/Latino

Marital Status
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widow/Widower

Sexual Orientation (OPTIONAL)
- ☐ Bisexual
- ☐ Lesbian/Gay
- ☐ Heterosexual/Straight
- ☐ Not Sure
- ☐ Other – feel free to explain

Employment Status
- ☐ Competitive Employment Full or Part Time
- ☐ Supported Employment Full or Part Time
- ☐ Unemployed – Looking for Work
- ☐ Retired
- ☐ Sheltered Employment
- ☐ Homemaker
- ☐ Student
- ☐ Disabled – Not in Workforce
- ☐ Not Seeking to Work
- ☐ Sheltered Workshop
- ☐ Volunteer

Living Situation
- ☐ Private Residence
- ☐ Foster Home
- ☐ Residential Care
- ☐ Crisis Residential
- ☐ Children 's Residential Treatment
- ☐ Institutional Setting
- ☐ Jail/Correctional Facility
- ☐ Homeless Shelter
- ☐ Other

Hurricane Victim
- ☐ Yes
- ☐ No

Served in the Military
- ☐ Yes
- ☐ No

Name: _____ DOB: _____ SS#: _____ Date: _____

3. What is the consumer's highest level of education completed? _____

4. Has the consumer been arrested in the past 30 days? _____ **If yes how many times?** _____

SECTION C: INSURANCE AND FINANCIAL INFORMATION

1. Please indicate the consumer's current insurance coverage.

☐	Medical Assistance (please provide MA number) _____
☐	Medicare
☐	Private Insurance
☐	No Insurance Coverage

2. Please provide the consumer's current income information.

Annual Income:	Monthly Income:
Income Source(s):	# of Dependents:

3. What benefits does the consumer currently receive? _____

4. What benefits has the consumer applied for and when? _____

SECTION D: LEGAL INFORMATION

1. Has the consumer ever been arrested? Yes ☐ No ☐

If yes, specify what the consumer has been charged with. _____

2. List any reported convictions. _____

3. Is the consumer on parole or probation or involved with the Department of Juvenile Services? Yes ☐ No ☐

Name: _____ DOB: _____ SS#: _____ Date: _____

4. Please indicate any pending charges. _____

_____

_____

5. Please list any pending court date(s). _____

SECTION E: AGENCY INVOLVEMENT

1. Please check all multi-agency involvement and briefly describe the services received.

☐	Department of Corrections/Local Detention Center	
☐	Homeless Services	
☐	Local Boards of Education	
☐	Local Department of Social Services	
☐	Protective Services (Adult/Child)	
☐	Somatic Services	
☐	Other (self help, support group, etc.)	

SECTION F: CLINICAL INFORMATION

1. Please provide the current DSM-5 diagnosis.

DSM-5 CODE	DISORDER

Name: _____ DOB: _____ SS#: _____ Date: _____

Please indicate the individual and agency that provided the diagnosis.
What is the date of the most recent diagnosis?

2. Please indicate the current medications consumer is prescribed.

Medication and Dosage	Doctor and Agency who Prescribed Medication	Reason for Medication	Does Consumer Take Medication as Prescribed?

3. Please complete substance abuse/use information.

Alcohol and Drug Used	Age at First Use	Last Date Used	Amount/Frequency	Method of Use

Name: _____ DOB: _____ SS#: _____ Date: _____

4. Please complete the following risk assessment chart.

	Never	Past Week-Month	Past Month-Year	Past 2+ Years	Please provide specific details of each item
Suicide Attempts:					
Suicidal Ideation:					
History of Clinical Deterioration:					
Aggressive Behavior/ Violence:					
Fire Setting/Arson:					
Self-injurious Behavior or Self-mutilation					
Sex Offense/Sexual Assault:					
If applicant answered **yes** to Sex Offense/Sexual Assault, please provide details.					
Is the applicant required to register through the MD Sex Offender Registry? Yes ☐ No ☐ Level of Sex Offense: Tier 1 ☐ Tier 2 ☐ Tier3 ☐					

5. Please complete the following chart for current and previous mental health and addiction treatment. Add additional sheets if necessary.

Type of Service	Dates of Service	Agency	Agency Contact Person	Agency Phone
Outpatient Mental Health Services (with a clinic or private practitioner)				
Mental Health Targeted Case Management Services				
Psychiatric Rehabilitation Program (PRP)				
Residential Rehabilitation Program (RRP)				
Partial Hospitalization Program (PHP)				

Mobile Treatment or Assertive Community Treatment (ACT)				
Residential Crisis Bed				

Name: _____ DOB: _____ SS#: _____ Date: _____

Type of Service	Dates of Service	Agency	Agency Contact Person	Agency Phone
Respite Services				
Acute Psychiatric Inpatient Hospitalization				
Residential Treatment Center (RTC)				
State Psychiatric Inpatient Hospitalization				
Other Mental Health Services				
Detox				
Outpatient Addiction Treatment				
Addiction Intensive Outpatient Program (IOP)				
Inpatient Addiction Treatment				
Methadone or Suboxone Maintenance Program				
Other Addiction Treatment Services				

6. Medical Necessity Criteria (MNC): All applicants must meet the Medical Necessity Criteria to receive Targeted Case Management Services. Please complete the following clinical criteria chart to determine eligibility and level of case management services.

Eligibility Criteria for Targeted Case Management Services:

Please write and/or type your response in the right hand column which justifies the specific eligibility criteria.

a. **Children and Adolescents** referred to as minors, with serious emotional disorders and who:	
i. Are at risk of, in need of continued community treatment to prevent, or are being discharged from inpatient psychiatric treatment *Please provide additional information that is not included in SECTION F, ITEM 5.*	☐ Yes ☐ No If answered yes, please provide an explanation:

ii. Are at risk of, in need of continued community treatment to prevent, or are being discharged from treatment in a RTC *Please provide additional information that is not included in SECTION F, ITEM 5.*	☐ Yes ☐ No If answered yes, please provide an explanation:

Name _____ DOB: _____ SS#: _____ Date: _____

Please write and/or type your response in the right hand column which justifies the specific eligibility criteria.

iii. Are at risk of an out of home placement due to multiple mental health stressors *Please provide additional information that is not included in SECTION F, ITEM 5.*	☐ Yes ☐ No If answered yes, please provide an explanation

b. **Adults** age 18 and over, who have a serious and persistent mental health disorder and who:	
i. Are at risk of, in need of continued community treatment to prevent, or are being discharged from inpatient psychiatric treatment *Please provide additional information that is not included in SECTION F, ITEM 5.*	☐ Yes ☐ No If answered yes, please provide an explanation:
ii. Are at risk of, or need continued community treatment to prevent being homeless *If yes, please explain current housing situation.*	☐ Yes ☐ No If answered yes, please provide an explanation:
iii. Are at risk of incarceration or will be released from a detention center of prison *Please provide additional information that is not included in SECTION D: LEGAL INFORMATION.*	☐ Yes ☐ No If answered yes, please provide an explanation:

c. **Children and Adolescents and Adults: Levels of Case Management Service** Consumer will be assessed to determine whether appropriate for General Level (a minimum of 2 services per month) or for Intensive Level (a minimum of 5 services per month)	
i. Is consumer linked to mental health and medical services? *If yes, please provide additional treatment information that is not included in SECTION F, ITEM 5.*	☐ Yes ☐ No If answered yes, please provide additional information:

ii. Does consumer lack basic supports for shelter, food and income? *If yes, please explain situation.*	☐ Yes ☐ No If answered yes, please provide an explanation:

Name: _____ DOB: _____ SS#: _____ Date: _____

Please write and/or type your response in the right hand column which justifies the specific eligibility criteria.

iii. Is the consumer transitioning from one level of care to another level of care? *If yes, please explain situation (e.g. transitioning from incarceration to community, RTC/inpatient psychiatric admission to outpatient services, etc.)*	☐ Yes ☐ No If answered yes, please provide an explanation:
iv. Does the consumer need to maintain community-based treatment and services? *If yes, provide justification and explain what is anticipated if not engaged in treatment.*	☐ Yes ☐ No If answered yes, please provide an explanation:

SECTION G: RECOMMENDATIONS

1. **Case Manager Safety:**

☐ Check here if it is recommended that consumer be seen at the clinic instead of home. Case management consumers are usually seen in their homes; however, if the case manager's safety is at risk, the consumer will be seen outside the home.

If selected explain: _____

2. **What service and/or benefits does the consumer need the Targeted Case Management Program to assist with? List the identified needs in priority order.**

3. **Please provide any other information that would be helpful for the case manager.**