Potter County Human Services
Blended Case Management Referral

Please attach proof of recent (within last 12 months) behavioral health diagnosis code. Examples include intake evaluation, psychiatric or psychological evaluation.

Consumer's Name:_____ SSN: _____ AGE: _____ DOB:_____

Address: _____ Zip:_____ Phone:_____

Is the consumer a Veteran? Y ___ N ___ If yes, does the consumer need assistance with Veterans Benefits? Y ___ N ___

MA Access #:_____ PHMCO:_____ BHMCO:_____

Private Insurance: _____ Medicare: _____ Other:_____

Parent(s) Guardian's Name: _____ Relationship:_____

Diagnosis - F Code(s): _____ _____

Psychiatrist:_____ Phone #:_____ Therapist:_____ Phone #:_____

Primary Care Physician: _____ Phone #:_____

Medical Condition V or Z Code(s) _____ Medications:_____

Psychiatric Medications: _____
[List all current Brand/Generic/Mg/Dose Medications]

List Psychiatric Hospitalizations with the last 12 months: _____
[List hospital(s) & dates of admission & dates of discharge]

_____

Child/Adolescent

- ☐ Six or more days of psychiatric inpatient treatment in the past 12 months? ___Y ___N
- ☐ Without BCM 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? ___Y ___N
- ☐ 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.? ___Y ___N
- ☐ GAF of 70 or below.

Adult

- ☐ Six or more total inpatient psychiatric days in the last 12 months? ___Y ___N Dates: _____
- ☐ Met standards for involuntary treatment (302, 303, 304)within the past 12 months? Y/N Dates:_____
- ☐ Currently receiving or in need of mental health services from 2 or more human service agencies or public systems such as D&A, Vocational Rehabilitation, Criminal Justice? __ Y ___N
- ☐ At least 3 missed community mental health service appointments, or, 2 or more face-to-face encounters with crisis intervention/emergency services personnel within the past 12 months. _____Y/N
- ☐ Documentation that the consumer has not maintained medication regimen for a period of at least 30 days.
- ☐ GAF of 60 or below

*Concrete, Measurable and Specific Reason for Blended Case Mgt.referral:*_____
[Benefits, Housing, Education/Voc., Navigating MH Services, etc.]

ALL Current Services: OVR/JobCoaching/Aging/C&Y/MRCM/D&A/OP/PHP/Parole/Probation,etc: _____

Blended Case Management services were explained to the consumer and consumer agrees to referral for Blended Case Management.

Consumer Signature:_____ Date:_____
Referral Signature: _____ Date: _____

Office use only:
Today's Date:_____ BSU# 531 - _____ Referred By: _____

Title/Position:_____ Agency Affiliation:_____ Phone #:_____

Please return completed form along with consumer's signature and Psychiatric Evaluation to fax number 814-544-9062.