HealthChoices Referral for

Contact the Referring County's CCBH Care Manager to Submit this form

(All the following information is required to activate a referral) Date______________________

Client Name: ____ DOB: _____________

MA ID# : _____________________________________ SS#: _________________________________

Current Address: ____

Current Phone #'s: ____

Case Manager: Name: __________________________ Phone #: _______________________

Who is making the referral? _____________________________ Phone #: ________________________

Facility________________________

Referral discussed with consumer, guardian and/or family? ______________________________

Response: ____

Primary Language Spoken:____

Release of Information Signed for Community Care, and Project Transition, if approved. Yes No

The individual must be over the age of 18 and meet the following:

I Diagnosis:

The person must have a primary diagnosis of Schizophrenia or other Psychotic disorder or Chronic Major Mood Disorder; SPMI, including dual diagnosis(MISA) and Personality Disorders

List Current Diagnosis, Medications and GAF Score (All Required)

Axis I: ____

Axis II: ____

Axis III: ____

Axis IV: ____

Axis V: ____

Current GAF: __________

Medications	**Dose**	**Frequency**

II. Indicators of Continuous High Service Needs:

A. Individuals must have three or more hospitalizations or incarcerations or a state hospital admission within the last year, or (5) face-to-face encounters with emergency personnel (psychiatric/arrests).

List Hospitalizations for mental health and substance abuse treatment in the last 12 months

Facility/Hospital	Dates	Outcome/Disposition

List Incarcerations/Emergency Encounters

Incarceration/Crisis Provider	Date of Encounter

B. The consumer must have an inability to participate in OR remain engaged in OR respond to traditional community based services. (Evidence exists of documented efforts to engage the consumer by a licensed treatment or case management provider for 45 days and supporting documentation that without BH treatment and support, the consumer's well-being and stability will be jeopardized).

List the current services the consumer is involved with or has been referred to in the last 45 days including case management:

Type of service   # of contacts/week   Date Last Used   Outcome

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

List Services in Last Year:

Type of Service   # of contacts/week   Date Last Used   Outcome

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

6. ____

C. The consumer must meet three (3) of the following: Please complete in detail the categories that apply.

1. There is evidence of current, co-existing mental illness and substance abuse/dependence.

List Substances Abused/Dependent:

Type	Frequency	Date Last Used

1. ____
2. ____
3. ____
4. ____

2. History of life threatening suicide attempts/life threatening self-harm within past two (2) years.

List Specific Behaviors:

Method	Date	Disposition

1. ____
2. ____
3. ____
4. ____

3. History of impulsive acting out, physical assault or uncontrolled anger that resulted in physical harm or real potential harm to other within last 2 years (ex. Assault, rape, arson)

List Behaviors:

Type of Impulsive/Acting Out Behavior	Type of Assault/Anger	Disposition/Outcome

1. ____
2. ____
3. ____
4. ____

4. Lack of support system: limited or no support from family, other professionals, friends, social programs.

☐ No Supports ☐ Limited Supports- List in Section IV.A

5. History of inadequate follow through with elements of a Treatment Plan that results in consumer's Psychiatric or medical instability (including lack of follow through taking medication, following a crisis plan, attending to health needs or maintaining housing).

List Behaviors Indicating Lack of Follow Through	What Happens

1. ____
2. ____

3. ____

4. ____

6. **Command hallucinations regarding harm to self or others with inability to ignore.**

List: Hallucinations and indicate if they are directed towards self or others and explain how these influence the consumer

____
____
____
____

7. **Threats of physical harm to others with or without follow through behavior within past two (2) years.**

List:

Threat | If follow-through, Method of Follow Through

1. ____

2. ____

3. ____

4. ____

8. **Current homelessness resulting in the person living on the street, in a shelter or substandard housing. (OR)**

The individual is residing in a state operated inpatient bed or maxed out on time served and in a Facility/institution on the state inpatient diversion list or a supervised community residence but *clinically assessed* to be able to live in more independent living if intensive services are provided or to prevent admission to a more intensive level of care.

If member is Age 18-25, please explain if the Transitional Age ACT has been considered for this member and if not, why:

____
____
____

III. Functional Level – Must have 1 of the following: (circle one)

(a) Global Assessment of Functioning (GAF) Scale Rating of 40 or below.
(b) A GAF Rating of 60 or below if the person has a documented history of violent or aggressive behavior.

Additional Information:

IV. Indicators of Consumer's Strengths, Supports, and Educational/Vocational History:

A. Identify consumer's support system, including family, friends, social, community,

List Supports and Relationship | Frequency of Contact

1. ____
2. ____

3. ____
4. ____

B. Identify Member Strengths:

1. ____
2. ____
3. ____
4. ____

C Educational/Vocational History:

List Education and Vocational History

1. ____
2. ____
3. ____
4. ____

V. Medical Conditions Activities of Daily Living:

A. Medical Conditions:

1. ____
2. ____
3. ____
4. ____
5. ____

B. Activities of Daily Living: Check all that apply

____Visually Impaired ______Hearing Impaired ______ Language Barrier

____ Independent with ADL's Primary Language:_____________________________

____ ADL Dependent Explain: ____

____

Additional Information: ____

____

____

____

____

Outcome of Community Care Review: **Date:________**

Outcome:

____**Not approved; Referral Source Notified on __________**

____**Approved for Referral to PT for tour and assessment**
Referral Faxed on:_______

____**Interview/Tour Completed on: _________ PT Decision:________________________**

___ **Referral source notified of final decision, by Community Care on:_______**