HealthChoices Referral for

Fax to North Central Community Care at 1-866-558-2618

Demographic, Identifying, and Contact Information:

(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

Please complete the following referral information as thoroughly as possible.

Admission Criteria

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 (DSM 5/ICD 10) and Medications(All Required)

Behavioral Health: ____

____

____

____

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

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____

____

____

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.

Additional Information:

III. 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. ____________________

IV. Medical Conditions and 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: ____________________

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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:_______

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