REFERRAL FOR YORK/ADAMS
COMMUNITY OUTREACH AND RECOVERY ESSENTIALS (CORE)

All of the following information is required to submit a referral:

Once completed, fax Referral to:

Community Care Behavioral Health (1-866-418-0366)

Date_____

Referral Source: _____ Phone #_____

Contact: _____

Client Name: _____ DOB: _____

MA ID#: _____

ROI for CCBH, and TrueNorth Wellness Services (if approved) Yes___ No_____

Current Address: _____

Current Phone #'s: _____

Guardian Name: _____ Guardian Phone #: _____

Guardian Address: _____

Case Manager: Name:_____Agency: _____Phone#_____

Admission Criteria

I. Diagnosis:

The Member has a primary diagnosis of Schizophrenia, Psychotic Disorders, or Chronic Mood Disorder as defined in the DSM 5 (or subsequent update). Individuals with a primary diagnosis of a substance abuse disorder, IDD, or brain injury are not the intended target population for this service.

List Current Diagnosis

Behavioral Health: _____

_____

_____

Medical Conditions/Physical Health issues: _____

_____

_____

II. Indicators of Continuous High Service Needs: (Circle One)

A. A Member who is currently residing in the community with serious mental illness who has been discharged from the state hospital program and who is utilizing the continuum of behavioral health residential programs, either in group or independent living settings.

Or

B. A Member in the community with serious mental illness who has not previously accessed the state hospital program, and who is currently accessing the continuum of behavioral health residential programs for additional support in order to prevent the need for access to the state hospital program, or other restrictive services.

Or

C. A Member with serious mental illness who previously accessed a state hospital program or other behavioral health residential programs, who has reached a point in their recovery which empowers them to be able to live independently, and who would benefit from the continuation of the support from this service, and after their transition.

Or

D. A Member with serious mental illness who currently resides in independent living, or other family settings, where multiple, intense behavioral health treatment interventions have not been able to provide this individual with an experience of long-term stability.

Background Information

When was the most recent Psychiatric Evaluation completed?

Date: _____ _____ None

Identify/List Member's Psychosocial Strengths:

1. _____

2. _____

3. _____

4. _____

Family or Other Natural Supports

List Supports	Relationship to Mbr	Frequency of Contact

Inpatient Mental Health Hospitalizations/ Substance Abuse Treatment

Facility/Hospital	Dates of Service	Level of Care	Outcome/Disposition

Current/Recent Community Based Mental Health Services
(Including case management)

Type of Service	Provider	# of Contacts Weekly	Dates	Active/ Closed	Outcome/Disposition

<u>If Member does not have case management, has it been offered</u>? ____ Yes ___ No ___ Member Declined

Referral made to: _____

<u>Justification for any of the above services continuing concurrently with CORE service:</u>

_____

Assessment of Current Functional Status

Ability to Care for Self ___Yes ___No ___Unknown ___ Not Reported

Appetite ___Unchanged ___Decreased ___ Increased ___Not Reported

Sleep ___Unchanged ___Decreased ___ Increased ___Not Reported

Insight ___Poor ___Fair ___Good ___Not Reported

Judgement ___Poor ___Fair ___Good ___Not Reported

Impulse Control ___Poor ___Fair ___Good ___ Not Reported

Memory ___Poor ___Fair ___Good ___ Not Reported

Socialization ___ Poor ___Fair ___Good ___ Not Reported

Assessment of Mental Health Symptoms

Hallucinations:
Current: Yes ___ No ___ History: Yes ___ No ___ Unknown ___

Auditory:
Current: Yes ___ No ___ History: Yes ___ No ___ Unknown ___

Visual:
Current: Yes ___ No ___ History: Yes ___ No ___ Unknown ___

Delusions:
Current: Yes ___ No ___ History: Yes ___ No ___ Unknown ___

Paranoia:
Current: Yes ___ No ___ History: Yes ___ No ___ Unknown ___

Other:
Current: Yes ___ No ___ History: Yes ___ No ___ Unknown ___

Other Description: _____

Mood:
Stable ___ Labile ___ Depressed ___ Erratic ___ Manic ___ Other ___

Affect:
Flat _____ Blunted __ Restricted ___ Elated ____ Congruent __ Other__

Assessment of Risk of Harm to Self

Suicidal Ideation:
Current: Yes ___ No ___ History: Yes ___ No ___ Unknown ___

Suicidal Attempts: History: Yes ___ No ___ Unknown ___

Plan: History: Yes ___ No ___ Unknown ___

Means: History: Yes ___ No ___ Unknown ___

Access to Weapons:
Current: Yes ___ No ___ History: Yes ___ No ___ Unknown ___

Additional Comments/Information: _____

Assessment of Risk of Harm to Others

Homicidal Ideation:
Current: Yes___ No ___ History: Yes ___ No ___ Unknown ___

Homicidal Attempts: History: Yes ___ No ___ Unknown ___

Plan: History: Yes ___ No ___ Unknown ___

Means: History: Yes ___ No ___ Unknown ___

Access to Weapons: History: Yes ___ No ___ Unknown ___

Additional Comments: _____

Intended Victims: _____

Assaultive Behaviors:
Current: Yes ___ No ___ History: Yes ___ No ___ Unknown ___

Aggressive Behaviors:
Current: Yes ___ No ___ History: Yes ___ No ___ Unknown ___

Self Injurious Behaviors:
Current: Yes ___ No ___ History: Yes ___ No ___ Unknown ___

Able to Contract for Safety:
Current: Yes ___ No ___ History: Yes ___ No ___ Unknown ___

Criminal History:

___ Awaiting Hearing ___ Awaiting Trial ___ Charges Pending ___ Current Parole

___ Current Probation ___ CYS ___ Drug Court ___ M H Court

___ House Arrest ___ Legal Fines ___ Incarcerated in last 12 months

___ None ___ Unknown ___ Other: _____

Education:

___ GED ___ HS Grad ___ Alternative Ed ___ Vocational

___ Associates Deg ___ Bachelors Deg ___ Masters Degree ___ Unknown

___Highest Grade Completed ___ Other: _____

Employment:

___ Competitive ___ Training/Educ ___ Work Program

___ Meaningful Activity ___ No Activity ___ Unknown

History of Domestic Violence:

___ Physical ___ Sexual ___ Witness to Abuse ___ None

Current Medications

Name of Medication	Dosage	Frequency	Prescriber

Compliance with Medications: ___ Yes ___ No ___ N/A ___ Unknown

Provider Checked Formulary ___ Yes ___ No ___ N/A ___ Unknown

Member Educated on Meds ___ Yes ___ No ___ N/A ___ Unknown

Member knows their PCP ___ Yes ___ No ___ Unknown at this time

Name of PCP/Practice: _____ Telephone**:** _____

Physical Health Plan: _____

Release(s) of Information Signed for Physical Health/Behavioral Health Integration:

____ Not needed ___ Yes ___ No ___ Unknown at this time

Current Medical/Physical Issues

Condition	Complexity Mild/Mod Severe	PCP/Medical Involvement Yes/No	Medication or Tx Required Yes/No	Mbr's Level Of Tx Compliance Poor/Fair/Good

Please Identify/List Early Signs of Regression and Known Successful Interventions

Behavior(s)	Intervention/Strategies

MISA Evaluation Completed: ___ Yes Date Completed: _____ ____ No

List Substances Abused/Dependent:

Substance/Type	Frequency of Use	Route of Admin	Date of Last Use

Additional Background Information

_____

_____

_____

Outcome of Community Care Review

Date: _____

Outcome:

_____ MNC Met

_____ MNC Not Met Reason: _____

_____ Referral Source Notified Date: _____ Name: _____

Initial Authorization Given:

_____ Units Beginning _____ to _____ Auth #: _____

Care Manager: _____ Date: _____