BEAVER COUNTY BEHAVIORAL HEALTH

1070 Eighth Avenue, Beaver Falls, PA 15010 Phone: 724-891-2827 Fax: 724-891-2865

CASE MANAGEMENT REFERRAL

DATE:	

CONSUMER'S NAME:		FOR CHILD ONLY: PARENT/GUARDIAN		M.A. ID #:	
ADDRESS:				PHONE:	

SSN:		DOB:		AGE:		INSURANCE:	Carelon	NONE	MA	OTHER:	

REASON FOR REFERRAL/NEED FOR SERVICE:

REFERRING AGENCY:		REFERRING INDIVIDUAL:		PHONE:	

DIAGNOSIS:

1.		2.	
3.		4.	

ADULT TREATMENT HISTORY

	# Days of psychiatric inpatient treatment in the last 12 months.		Check if 302/304 C Criteria were met in the last 12 months.

Involved with or in need of any of the following services:

- Drug & Alcohol
- Vocational Rehabilitation
- Criminal Justice
- Other:________________________

History of any of the following:

- At least 3 missed community mental health appointments in past 6 months
- Two or more face to face encounters with Crisis or Emergency services in the past 12 months
- Documentation that consumer has not maintained her/his medication regimen for at least 30 days
- Involuntary outpatient commitment.

CHILD/ADOLESCENT TREATMENT HISTORY

	# Days of psychiatric inpatient treatment in the last 12 months.		Check if at risk of out of home placement without BCM Services?

Currently receiving or in need of services from 2 or more of the following Human service or public system agencies:

☐ Mental Health ☐ Child Welfare ☐ Other________________________

☐ Education ☐ Juvenile Justice

Check if recommended for MH services by CASSP or Multi-service Children's Team

I agree to be contacted by BCBH to further discuss Case Management Services.

Consumer/Parent or Guardian Signature:____________________________ **Date:** ____________

FOR BCBH USE ONLY

041:	Date Received:	CM:

DISPOSITION: ☐ Accepted ☐ Denied ☐ Withdrawn **PROGRAM:** ☐ BCM ☐ ACM

	Check if the individual is in need of BCM services as indicated through medical necessity criteria and in conjunction with clinical information and the professional judgment of the reviewer

Reviewer/Supervisor:	Date Assigned: