REFERRAL FORM FOR BLENDED CASE MANAGEMENT

1598 Virginia Ave Monaca Pa 15061

Please check all areas that apply

Date: __________ Individual's Name: ______________________________ MA Number: ____________________

Individual's Address: ______________________________ Individual's Phone Number: ______________

Referring Agency: ______________ Person Referring: ______________ Referral Phone Number: ______________

ADMISSION CRITERIA

Following are the eligibility requirements for Blended Case Management. Please complete this referral form completely, and attach most recent copy of psychiatric evaluation (ideally within past 12 months).

Must Meet Criteria I, II and one or more of Criteria III

I. DIAGNOSIS

Diagnosis within DSM V (or subsequent revisions), excluding those with a principal diagnosis of mental retardation, psychoactive substance abuse, organic brain syndrome or a V-code; **COPY OF PSYCHIATRIC EVALUATION MUST BE ATTACHED TO THIS REFERRAL SHEET**; **AND**

II. FUNCTIONING LEVEL

Global Assessment of Functioning Scale (as specified in the DSM IV-R or revisions thereafter) ratings of 60 or below; **AND**

III. INDICATORS OF CONTINUOUS HIGH SERVICE NEEDS: (Must have one of the following criteria)

___ a. Six or more days of psychiatric inpatient treatment in the past 12 months;

___ b. Met Standards for involuntary treatment within the past twelve months;

___ c. 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 Drug/Alcohol, Vocational Rehabilitation, Criminal Justice, etc.;

___ d. At least 3 missed community mental health service appointments, or two or more face-to-face encounters with crisis intervention/emergency services personnel within the past 12 months, or documentation that the consumer has not maintained his/her medication regimen for a period of at least 30 days.

EXCEPTION CRITERIA

Any individual who may benefit from blended case management services, but does not meet the requirements identified above may be eligible for blended case management services upon written prior approval by the Value Behavioral Health Managed Care Organization or Beaver County Behavioral Health, as applicable.

OUTSIDE AGENCIES

Agency Name: ______________________________ Agency Phone: ______________

Address: ______________________________

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Please have individual sign Release of Information for your agency and fax with referral form and evaluation to 724-371-0937, Attn BCM Supervisor

Individual Signature: ______________________________ **Date:** ______________

Clinician Signature: ______________________________ **Date:** ______________

☐ **Individual accepted into program** **Signature:** ______________________ **Date:** ______________

☐ **Individual not accepted into program** **Signature:** ______________________ **Date:** ______________

Contributing factors related to denial of admission at this time (if applicable):

Correspondence with referral source:

Merakey Staff___________________ ***spoke to; emailed; faxed;*** **Referral Source Staff**________________ on **Date**________
and informed the referral source that _________________ ***was/was not*** admitted to the BCM program at this time.