Montgomery County Child & Adolescent Blended Case Management Referral Form

Montgomery County offers a range of case management services for children that are supportive and aimed at promoting resiliency. While services vary in level of intensity, this referral application will help to identify the appropriate case management support that will meet the goals of the youth and parents/guardians. *This application is to be completed in partnership by youth, family, and referral source/support person.*

REQUIRED SUPPORTING DOCUMENTATION (*Attach documentation and submit referral to case management agency in individual's catchment area of residency)*

- ❖ Documentation of a DSM-5 (or revisions thereafter) Diagnoses *(see pg.5 for diagnosis exclusions)*
  - Diagnosis documentation must be provided by a Mental Health Professional within 1 year of referral.
- ❖ Documentation of Eligibility criteria for BCM Services. *(see pg.5 for explanation of eligibility criteria)*

REFERRAL SOURCE			
Name:		Title:	
Agency:		Phone #:	
Date of Referral:		Email:	

CHILD'S INFORMATION			
Name:			
(First)	(Middle Initial)		(Last)
Preferred Name/Nickname:		Ethnicity (optional):	
Date of Birth:	SS#:		MHX#:
Gender Assigned at Birth:		Chosen Gender:	
Physical Address		(City)	
(Address Line 1)			
(Address Line 2)		(State/ Zip Code)	
Home Phone #:		Cell Phone #:	

INSURANCE INFORMATION			
Private Insurance	☐Y ☐N	Group #:	Policy #:
		Insurance Company:	
Medical Assistance	☐Y ☐N		
Magellan Behavioral Health	☐Y ☐N		
Pending Insurance	☐Y ☐N	Specify:	
Physical Health Provider:	(NAME/NAME OF PRACTICE)		

PARENT/GUARDIAN INFORMATION			
Parent #1 Name:			
Home #:		Cell #:	Work #:
Legal Custody	☐Y ☐N	Physical Custody	☐Y ☐N

Parent #2 Name:			
Home #:		Cell #:	Work #:
Legal Custody	☐Y ☐N	Physical Custody	☐Y ☐N

If parents do not have physical or legal custody, please identify guardian:

Guardian Name:		Relationship:	
Physical Address		(City)	
(Address Line 1)		(State/Zip code)	
(Address Line 2)			
Home #:		Cell #:	Work #:

FAMILY INFORMATION

Household Members

Name:		Age:		Relationship:	
Name:		Age:		Relationship:	
Name:		Age:		Relationship:	
Name:		Age:		Relationship:	
Name:		Age:		Relationship:	
Name:		Age:		Relationship:	
Name:		Age:		Relationship:	

Do any family members receive behavioral health service?	☐Y ☐N	Describe Services:	

MEDICAL INFORMATION

DSM Diagnosis	Code

Medications	Dosage	Purpose

Allergies:			
Primary Care Physician:		**Phone #:**	
PCP Physical Address			
(Address Line 1)		(City)	
(Address Line 2)		(State/Zip code)	

Acute Inpatient Hospitalizations Within Last 2 Years

Dates	Facility	Reason for Admission

BEHAVIORAL HEALTH SERVICES

If child is currently involved in or is in the process of being referred to for treatment, please check all that apply.

		Provider	Phone #
Outpatient	☐Y ☐N		
Intensive Behavioral Health Services	☐Y ☐N		
Family Based Services	☐Y ☐N		
Summer Therapeutic Activities Program	☐Y ☐N		
Therapeutic After School Program	☐Y ☐N		
Multi-Systemic Therapy	☐Y ☐N		
Transition to Independence	☐Y ☐N		
Peer Support	☐Y ☐N		
Partial Hospital	☐Y ☐N		
Inpatient Hospital	☐Y ☐N		
Residential Treatment Facility	☐Y ☐N		
Community Residential Rehabilitation Host Home	☐Y ☐N		
Substance Use Services	☐Y ☐N		
Other (describe):	☐Y ☐N		

Please list any former Behavioral Health Services/Providers used in the past (if any):_____

_____

_____

COMMUNITY SUPPORTS & SERVICES

		Provider/Contact	Phone #
Office of Children and Youth	☐Y ☐N		
FamilyWorx	☐Y ☐N		
Respite	☐Y ☐N		
Other (describe):	☐Y ☐N		

LEGAL INVOLVEMENT

		Contact	Phone #
Juvenile Probation	☐Y ☐N		
Other	☐Y ☐N		

SCHOOL INFORMATION			
School District:		School:	
Grade Level:		School Main Phone #:	
Contact Person:		Contact Phone #:	
IEP	☐Y ☐N		
Graduated HS	☐Y ☐N	Year graduated HS:	

NEED FOR CASE MANAGEMENT SERVICES

Reason for referral/How would the child benefit from case management services? What are their needs surrounding MH, living situation, financial, benefits, community supports, socialization, advocacy, etc?

Signature (if over age 14):		**Printed Name:**	
Date signed:			
Parent/Guardian Signature:		**Printed Name:**	
Date signed:			

Diagnosis exclusions and Eligibility Criteria

Language used below has been updated from the original 55 PA Code 5221 or OMH-93-09 respectively to be more inclusive and recovery –based.

(1) **Diagnosis:**	(2) **Treatment History** shall be established when *one* of the following criteria is met:
Diagnosis within DSM-5 (or revisions thereafter) **excluding those with a principal diagnosis of intellectual/developmental disability, psychoactive substance abuse, traumatic brain injury, or a V-Code**.	(i) Six or more days of psychiatric inpatient treatment in the past 12 months; (ii) Without blended case management services would result in placement in an inpatient unit, residential treatment facility, or other out-of-home placement, including Children and Youth services or juvenile court placements; (iii) Currently receiving **or in need of** mental health services and receiving or in need of services from 2 or more human service agencies or public systems such as Education, Children & Youth Services, Juvenile Justice, etc.

- **An adult, child, or adolescent who currently receives Intensive Case Management or Resource Coordination services.**
- **An adult, child or adolescent who needs to receive blended case management services, but who does not meet the requirements identified above**, may be eligible for Blended Case Management upon review and recommendation by the County Administrator or their designee, or the Behavioral Health Managed Care Organization, as applicable.