To be completed upon receipt by Case Management Office					
Agency		Date Referral Received		Date Referral Assigned	

CHILD AND ADOLESCENT BLENDED CASE MANAGEMENT REFERRAL APPLICATION 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 support, this referral application will help to identify the appropriate level support that will meet the child and family goals. This application is to be completed in partnership by the youth/family and referral source.

A psychiatric/psychological evaluation completed within the last six months must accompany this referral. Please forward referral to appropriate case management office (list attached).

Youth Information Date of Referral: _____

First Name: _____ Middle Initial: _____ Last Name: _____

DOB: _____ Ethnicity: _____ Sex: _____ SS#: _____ BSU#: _____

Address and Contact Phone Numbers:

Address: _____ Home #: _____
_____ Cell #: _____

Youth's Insurance

☐ Private Insurance: _____
Group#: _____ Policy#: _____

☐ Medical Assistance
Magellan Behavioral Health Yes ☐ No ☐ Pending ☐
Physical Health Provider _____

Parent Information

Mother _____ Father _____
Home Phone _____ Home Phone _____
Cell _____ Work _____ Cell _____ Work _____
Mother – Physical Custody? Yes ☐ No ☐ Father – Physical Custody? Yes ☐ No ☐
Mother – Legal Custody? Yes ☐ No ☐ Father – Legal Custody? Yes ☐ No ☐

**If parents do not have physical or legal custody, please identify guardian*
Guardian: _____ Relationship: _____
Address: _____ Contact#: _____

Household Information

Name	Age	Relationship	Do they receive MH services? (describe)

Cultural Considerations (language, ethnicity, religion, etc.)

DSM Diagnosis

_____ Code: _____
_____ Code: _____
_____ Code: _____
_____ Code: _____
_____ Code: _____

Physical and Psychiatric Medications (please include name and dosages)

Primary Care Physician

Doctor _____
Practice _____
Address _____ Phone _____
Date of last physical* _____
Allergies _____

*attach copy if available

Inpatient Psychiatric Hospitalizations

Facility	Date	Reason for Admission

Community Support

Please check all services that the youth has had previous involvement with and if the youth is currently receiving the service please provide agency name, staff contact and phone.

Service	Date(s)	Currently Involved	
Outpatient		☐ YES Agency: _____ Staff Contact: _____ Phone:	☐ NO
Behavioral Health Rehabilitation Services		☐ YES Agency: _____ Staff Contact: _____ Phone:	☐ NO
Transition to Independence Process		☐ YES Agency: _____ Staff Contact: _____ Phone:	☐ NO
Multisystemic Therapy		☐ YES Agency: _____ Staff Contact: _____ Phone:	☐ NO
Family Based Services		☐ YES Agency: _____ Staff Contact: _____ Phone:	☐ NO
Partial Hospital		☐ YES Agency: _____ Staff Contact: _____ Phone:	☐ NO
Therapeutic Foster Care		☐ YES Agency: _____ Staff Contact: _____ Phone:	☐ NO
Residential Treatment Facility		☐ YES Agency: _____ Staff Contact: _____ Phone:	☐ NO
Substance Use		☐ YES Agency: _____ Staff Contact: _____ Phone:	☐ NO
High Fidelity Wraparound		☐ YES Agency: _____	☐ NO

		Staff Contact: _____ Phone:	
Office of Developmental Disabilities		☐ YES Agency: _____ Staff Contact: _____ Phone:	☐ NO
Office of Children & Youth		☐ YES Agency: _____ Staff Contact: _____ Phone:	☐ NO
Juvenile Probation Office		☐ YES Agency: _____ Staff Contact: _____ Phone:	☐ NO
Other		☐ YES Agency: _____ Staff Contact: _____ Phone:	☐ NO

School Information

School: _____ Grade: _____
Contact Person: _____ Phone: _____
School District: _____

☒ IEP/504 Plan (check if applicable)
☐ Graduated High School (check if applicable)

Referral Source

Name _____ Title _____ Phone _____
Agency Address _____

Contact with Referral Source ☐ YES ☐ NO
Comments: _____

Reason for Case Management Referral

How would the youth benefit from case management services? What are their needs surrounding medical, social, housing, education, and other services?

Signature (if over age 14) Parent/Guardian Signature

_____ Date _____ _____ Date _____

Printed Name (if over age 14) Parent/Guardian Printed Name

_____ Date _____ _____ Date _____

Montgomery County Children and Adolescent Case Management Offices

Central Behavioral Health
1211 DeKalb Street
Norristown, PA 19401
Phone: 610-272-3042
Fax: 215-392-3166

Child and Family Focus
2935 Byberry Rd, Suite 108
Hatboro, PA 19040
Phone: 215- 957-9771
Fax: 215-957-9785

Community Services of Devereux
1041 West Bridge Street
Phoenixville, PA 19460
Phone: 610-933-8110
Fax: 610-933-7451

Creative Health Services
11 Robinson Street
Pottstown, PA 19464
Phone: 610- 326-2767
Fax: 610-326-6987

NHS Human Services
2506 North Broad Street, Suite 201
Colmar, PA 18915
Phone: 215-716-9002
Fax: 215-716-9038

Penn Foundation
807 Lawn Avenue
Sellersville, PA 18960
Phone: 215- 257-2114
Fax: 215-257-4716

Lower Merion Counseling Services
850 Lancaster Avenue, Second Floor
Bryn Mawr, PA 19010
Phone: 610-520-1510
Fax: 610-520-1517