MONTGOMERY COUNTY RECOVERY COACHING
REFERRAL APPLICATION FORM

Montgomery County offers Recovery Coaching (case management) services that are supportive and aimed at promoting recovery. ***This referral is to be completed together with the participant and referral source/support person.***

A psychiatric/psychological evaluation completed within the ***last six months*** **must be completed before enrollment is complete. However, if you do not have a recent evaluation, and are unsure of how to get one, please contact your local Community Behavioral Health Center.**

Section I: Demographic Information

Date of Referral:		MHx# (if known):		SSN:	
Applicant's Name:			DOB:	Age:	Gender:
Address (if homeless, last known address):					
Home#:	Work#:		Cell#:	Email:	
Emergency Contact:			Phone#:	Email:	

Section II: *To be completed by the applicant*:

Reason for Referral? How would you benefit from Recovery Coaching supports? What are your needs?

Services and Supports (Mark C for current service; P for past service; R for referral made to service; or N for needed):

MENTAL HEALTH				MEDICAL		D&A	
	Outpatient		IOP		PCP		AA/NA
	Admin Case Mgt		CPS		Specialists (List):		Dual Residential Placement
	RC/BCM		Career Support		Treatments (e.g. dialysis, chemo)		Halfway House
	CTI		Psych Rehab				Methadone Treatment
	JRS		ACT	FORENSIC			Outpatient
	TIP		Peer Resource Center		Current/Pending Charges	Other (Please list)	
	CRR or LTSR		Clubhouse		Sex Offender Program		
	PCBH		Supported Housing		Probation/Parole		

Other services and supports that are currently needed or in place:
_____

Section III: *To be completed by Referral Source*:

Referred by:		Title/Position:	
Agency:		Phone/Email:	

Reason for Referral? How would this person benefit from Recovery Coaching supports? What are his/her needs?
_____

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Section IV: Insurance and Income:

Type of Insurance:	Provider:	Income Source:	Monthly Amount:
Medical Assistance		**Employment**	
Medicare		**SSI/SSDI**	
Private		**Cash Assistance**	
Pending, specify		**Other, specify**	
Spend-down, specify			

Section IV: Eligibility Criteria for RC Services:

Diagnosis – The individual being referred must have a diagnosis within DSM V excluding those with a principal diagnosis of mental retardation, psychoactive substance abuse, organic brain syndrome.

Treatment History – One or more of the following criteria must be met; **Please check ALL that apply:**

☐	6 or more days of psychiatric inpatient treatment in the past 12 months
☐	Met standards for involuntary treatment (302) within the past 12 months
☐	Currently receiving or in need of 2 or more human service agencies/public systems (MH, D&A, OVR, OCY, Crim Just, etc.)
☐	At least 3 missed community MH appointments within the past 12 months
☐	2 or more face to face encounters with crisis/emergency services within the past 12 months
☐	Documentation of inability to maintain medication regime for a period of at least 30 days

DSM V Diagnosis

Diagnosis:		**Code:**	
Diagnosis:		**Code:**	
Diagnosis:		**Code:**	
Diagnosis:		**Code:**	

I give permission to the Recovery Coaching agency receiving this referral to coordinate with the referral source and Emergency Contact listed above in order to complete the application and initial enrollment process.

Signature of Applicant:	**Date:**

Signature of Referral Source	**Date:**

FOR OFFICE USE ONLY

RC assigned:	Date Assigned:	Date Referral Completed:
RC Team Leader's Signature:		