DBHIDS
DEPARTMENT of BEHAVIORAL HEALTH and INTELLECTUAL disABILITY SERVICES

C·B·H
Community Behavioral Health
A DIVISION OF DBHIDS | CBHPHILLY.ORG

DBHIDS INTEGRATED INTAKE APPLICATION PACKET

The Department of Behavioral Health and disAbility Services has developed a single intake for all contracted Behavioral Health Services. This form will be available on the DBHIDS and CBH Websites. Please use these instructions to assure the accurate completion of this comprehensive form. This application is also available in a fillable form for Adult Case Management only.

Application Attachments
All Forms required to complete **FOR ADULT CASE MANANGEMENT**:

- DBHIDS Integrated Intake
- Authorization to Obtain, Use and Disclose Health Information
- Psychiatric Evaluation
- Criminal History and Needs Assessment (optional)
- Medical Evaluation (optional)

PLEASE NOTE THE FOLLOWING:

Please print clearly and legibly; or you may select the electronic referral version. Illegible forms will be returned as incomplete.

Please complete application in entirety. Please refer to the explanations below for clarification on terminology.

Documentation of Criminal Mental Health Court or Prison MH Reentry programs is required for incarcerated participants.

Submission of this application does not guarantee acceptance to a case management program.

Referrals for adult Targeted Case Management must be emailed directly to the service providers. Provider information is attached.

DBHIDS INTEGRATED INTAKE
APPLICATION PACKET DIRECTIONS

Page One

Referral Contact Person -- Please provide the contact that would receive questions or decisions on this application.

Participant Name: (Last/First/Middle): Please print (No nicknames).

AKA Type: Fill in either-- Alias; Former Name; Maiden Name; Birth Name; Married Name; Other; Error

Address: Participant's permanent address --Please indicated where the personal is living if they are currently in the community, or if they are not in the community, the most recent place they were living.

Gender: (1)Male (2)Female (3)Transgender (4)Male to Female (5)Female to Male (6)Intersex (7)Genderqueer

Ethnicity Code: Fill in either Hispanic or Non-Hispanic

Race: Fill in one of the following: Refused to answer; Black/African American; Alaskan Native; Native American/American Indian; Asian; Bi-racial/mixed; White/Caucasian; Pacific Islander/Native Hawaiian; Other; Unknown

Sexual Orientation: (1) Heterosexual (2) Lesbian (3) Gay (4) Bisexual (5) Asexual (8) Other (9) Unknown

Date of Birth: Include full year-- e.g. 01/22/1967

BSU Status: Enter BSU Number if the person is registered with a Community MH/IDS Center

CIS#: CBH Client Identification Number, if the person is registered with CBH

Insurance: Provide information on Insurance Coverage. Please utilize your agency's access to the State of Pennsylvania's Department of Public Welfare Electronic Verification system (EVS). First distinguish the Primary Coverage Type: FFS Medicaid; Managed Medicare; Medicaid; Other; Private; Unmanaged Medicare; VA. Then, only if the answer is FFS Medicaid, please specify the carrier for Physical Health Coverage: Aetna Better Health Medicaid; Health Partners Medicaid; Keystone First Medicaid; United Medicaid.

Income Source(s): Please identify a source of income for your participant. If any source of income is declared, a monthly figure is required, even if estimated or rounded. Income categories are: SSI, SSDI, SSA, Work, Alimony, Pension/Retirement, Trust Fund, Stocks/Annuities, VA, Other, None.

Name of Payee: Name of person officially designated to receive SSI, SSDI or other payments.

Veteran Status: Enter Yes or No if the person served in the military. If the answer is yes, describe the discharge status and indicate whether the person is eligible for VA healthcare benefits.

Personal Identification Forms: Please indicate what forms of identification you currently have. Please note these forms are very important to maintain at all times.

Current Living Environment: Please use the Codes for Living Environment listed later in these instructions. This code applies to where the person is currently staying at the time of referral. A homeless person staying on an EAC Unit should be listed as code 19—EAC Unit.

Page Two

Current Hospitalization/Incarceration: Please list the name of the facility, the Admit Date and Anticipated Discharge Date. Please also list the Facility Contact name, title, and phone number.

Psychiatric Assessment: Please list all ICD-10 Codes with DSM 5 Diagnoses. This must match the completed psychiatric evaluation.

Medications: Including a medication list instead of inputting medications is acceptable. In order to input a medication, however, complete info is required for each medication, or the application cannot be processed.

Page Three

Medical Issues/Physical Disabilities: For each physical and/or medical challenge listed, please provide an indication of whether it is episodic, chronic, or acute and whether there has been recent treatment.

Substance Use/Abuse: If, in the last year, there has been any substance use/abuse, the section should be completed.

Forensic System Involvement: The Criminal History and Assessment Form must be completed and accompany this application.

Page Four

Family Status: Provide info on whether or not the participant has children. If the person has children, the rest of the info is required: total number of children, the number of custodial children, and number of dependent children.

Behavioral Risk Factors: Behaviors listed as anything other than "Not at all" must be accompanied by a date of last instance and a written description of the circumstances and assistance needed to manage the behavior.

Page Five

Meaningful Life Activities: Assess the skills and need for supports under each area.

Psychosocial; Educational/Vocational; Social/Recreational/Leisure Areas:

Please indicate all activities under each area, as well as desired activities. See DBHIDS Codes used for Integrated Intake attached. At least 1 code is required for both Current and Desired Activities for each category.

Page Six

Housing Preferences:

Please describe the type of living situation you would most want to live in.

Housing Preferences (cont'd.): Please check boxes to indicate which areas the person is willing to live in Philadelphia. At least 2 options are required.

Forms Requiring Signature

Authorization to Obtain, Use, and Disclose Health Information: This form is a requirement for disclosure of the information within the application so that it may be re- released to other services providers.

Medical Evaluations

The Medical Evaluation in this packet is used for the majority of Community Mental Health Residential Services. The exception is for those programs that are licensed as Personal Care Boarding Homes. If the person is being recommended for one of these programs, please complete the MA-51 in lieu of the DBH/IDS form. It must be signed by a licensed physician.

Psychiatric Evaluation

Please assure that all items are completed, including DSM codes for all diagnoses. Form must be signed by a licensed psychiatrist and dated. This should match the psychiatric assessment on p.2

Criminal Assessment Form

With any history of criminal court involvement, the Criminal History and Assessment Form must be completed in its entirety. If there is no history of Criminal Activity or Court Involvement, then the form must be filled in with the participant's name and signed by the submitting party.

DBHIDS INTEGRATED INTAKE 2016

* Asterisks indicate required fields, ** Double asterisks indicate conditionally required fields

***Referral Contact Person** _____ ***Referral Contact Address:** _____

***Agency or Relationship** _____ _____

***Phone** _____ ***Email** _____ **Fax:** _____

Please refer to Instructions and Application Guide to complete the application.

Participant's Name

***Last** _____

***First** _____ **Middle** _____

AKA _____

AKA Type _____

See Instructions for the AKA Types.

***Gender** ☐ ***Race** _____

***Ethnicity** _____ ***Sexual Orientation** ☐

***Social Sec. #** _____

***Date of Birth:** _____

***Citizenship** ☐ U.S. ☐ Permanent Resident

☐ Temporary ☐ Refugee ☐ Undocumented Person

***English Speaking** ☐ Yes ☐ No ☐ Limited Other Language: _____

***Current Address**

_____

_____ , P A _____

BSU Status

Participant BSU # _____ - _____

CIS # _____

Highest Level of Education completed: _____

***Participant's Phone #** _____

***Participant's Email** _____

***Emergency Contact Name:** _____

***Phone #** _____

Insurance: See instructions for insurance categories

***Primary Coverage Type:** _____ **Secondary Coverage Type:** _____

***Primary Physical Health Coverage:** _____ **Secondary Physical Health Coverage:** _____

***Income source(s):**

	Type	**Amount
1	_____	$ _____
2	_____	$ _____

Name of Payee (if any):

***Veteran Status:** Did the person serve in the military? ☐ Yes ☐ No **If "Yes", what was the discharge status? _____

**If "Yes", are you eligible for VA Healthcare Benefits? ☐ Yes ☐ No

Personal ID Forms Do you have government issued documents and/or ID? Please indicate below and clarify anything extraordinary.

Photo I.D. ☐ Yes ☐ No **Birth Certificate** ☐ Yes ☐ No **Social Security Card** ☐ Yes ☐ No _____

Current Living Environment** **Provide Code:** ____ ***See Appendix B for Living Environment CODES

a.) If person is presently **street** homeless, how many days _____

b.) # times **street** homeless in past 12 months _____

c.) Total # of residences in past 12 months **d.)** _____

months at current residence _____

e.) What barriers exist for person remaining in current residence? _____

Participant Name _____ **Date of Birth:** _____

*Current Hospitalization/Incarceration (Physical Health, Behavioral Health, Incarceration, Neither)	Psychiatric Assessment
Facility _____	**ICD 10/DSM 5 Code:** **DIAGNOSIS:**
Admit Date ___ / ___ / _____	*BH Dx 1 _____ _____
Anticipated Discharge Date ___ / ___ / _____	*BH Dx 2 _____ _____
Contact Name: _____	*BH Dx 3 _____ _____
Contact Phone: _____	
Contact Email: _____	*Other Dx _____
Contact Title: _____	*Other Dx _____

Recent Hospitalization/Incarceration	Last 12 months	Last 6 months
# **Crisis Response Center/Mobile Emergency Team Visits**		
# **Involuntary Commitments (302s)**		
# **Times Hospitalized - Psych (Include forensic inpatient)**		
# **Days Hospitalized - Psych (Include forensic inpatient)**		
# **Detox Episodes**		
# **Days in D&A Rehab (Residential)**		
# **Days in D&A Rehab (Out Patient)**		
# **Days Incarcerated**		

Medication Regimen

a.) Has the person been prescribed medication? ☐ Yes ☐ No

b.) Is the person agreeable to taking medication? ☐ Yes ☐ No

c.) Does the person take medication that requires bloodwork? ☐ Yes ☐ No

(If so, which medication?) _____

d.) What resources does the person have to ensure medications are taken properly?
(Include human resources, finances, pharmacies, etc.)

_____

e.) Medications Summary:

**Medication Name	**Dose Amount	**Dose Frequency	**Taken as Prescribed?	**How long Prescribed?

Participant Name _____ **Date of Birth:** _____

ADDITIONAL HEALTH INFORMATION: (Allergies, Health Issues, etc.)

_____

_____

Medical Issues/ Physical Disabilities

Do you have any medical or physical concerns? ☐ **Yes** ☐ **No**

_____ ☐ Episodic ☐ Chronic ☐ Acute Recent Treatment? ☐ Yes ☐ No

_____ ☐ Episodic ☐ Chronic ☐ Acute Recent Treatment? ☐ Yes ☐ No

_____ ☐ Episodic ☐ Chronic ☐ Acute Recent Treatment? ☐ Yes ☐ No

a.) Does the person use medication, devices or appliances for a physical disability? ☐ Yes ☐ No

If Yes, please explain: _____

b.) Does the condition impede the person's daily activity? ☐ Yes ☐ No

c.) Does the person cooperate with needed medical care? ☐ Yes ☐ No

d.) What assistance is needed to maintain health? _____
(Include human resources, finances, pharmacies, etc.)

***Substance Use/Abuse Issues in last year?** ☐ Yes ☐ No *(If yes, complete below)*

a.)

**Substance Used	**Amount	**Frequency	**Age of First Use	**Date of Last Use	**Method

b.) **Is person currently in D & A treatment? ☐ Yes ☐ No If Yes, please explain: _____

c.) **What is the person's longest period of sobriety? _____

Note: If not in treatment and use is current, PCPC/ASAM may be required. Contact DBHIDS Program Staff.

d.) If NOT in treatment, is Participant interested in participating in D&A treatment? ☐ Yes ☐ No

e.) Is Participant interested in being connected with a D&A support group (which could include, but is not limited to 12-step programs)? ☐ Yes ☐ No

f.) If in a 12-Step program, does Participant have a Home Group? ☐ Yes ☐ No ☐ Not in 12-Step

g.) Does participant have a Recovery Sponsor? ☐ Yes ☐ No ☐ Desires connection

With any history of criminal court involvement, the Criminal History and Assessment Form must be completed in entirety.

Forensic System Involvement

a.) Has the person been convicted of a crime? ☐ Yes ☐ No

b.) Has the person ever been convicted of a felony? ☐ Yes ☐ No

c.) Has the person ever been incarcerated? ☐ Yes ☐ No *From: _____ *To: _____

d.) Is the person currently on probation or parole? ☐ Yes ☐ No Until: *(mm/dd/yyyy)* ___/___/___

e.) Is the person required to register under Megan's Law? ☐ Yes ☐ No

f.) Is the person a participant in FJD MHC? ☐ Yes ☐ No

Parole/Probation Officer Name _____ Parole/Probation Officer Phone _____

Participant Name _____ **Date of Birth:** _____

Relationship Status^:

☐ Never Married ☐ Separated ☐ Partnered ☐ Widowed

☐ Married ☐ Divorced

^ Effective Jan. 1, 2005 Common Law Marriage was abolished in PA. Prior are grandfathered into data. Please contact DBHIDS Program Staff for instructions if person had a Common Law Marriage

Family Status*: ☐ No Children ☐ Unknown

☐ Children, not pregnant ☐ Pregnant, no other children ☐ Pregnant, with additional children

Total Number of Children ☐ Male ☐ Female

Total Number of Dependent Children ☐ Male ☐ Female

If seeking permanent housing, will participant have custody of children? ☐ Yes ☐ No

Total Number of Custodial Children ☐ Male ☐ Female

Does family have an active case with DHS?

☐ Yes ☐ No

Please provide any necessary clarification to Family Status and/or Child custody. If family works with DHS, this question is required.

_____

***Behavioral Risk Factors**

(Choose one for each different area)

1=Not at all 2=Occasionally 3=Often 4=Very often

a.) Suicidal thoughts/behaviors **1**☐ 2☐ **3**☐ **4**☐

Circumstances and date of last instance _____

How much assistance must the person have in this area? _____

b.) Assaultive/Aggressive behaviors 1☐ 2☐ **3**☐ 4☐

Circumstances and date of last instance _____

How much assistance must the person have in this area? _____

c.) Fire setting behavior 1☐ 2☐ **3**☐ 4☐

Circumstances and date of last instance _____

How much assistance must the person have in this area? _____

d.) Aggressive or illegal sexual behavior 1☐ 2☐ **3**☐ 4☐

Circumstances and date of last instance _____

How much assistance must the person have in this area? _____

e.) Using the checkbox provided, describe person's ability to be aware of environmental risks.

1. Adequate 2. Needs Planning 3. Needs Intensive Support

1☐ 2☐ 3☐

Please explain. _____

f.) Other identified behavioral risk factors (Optional): _____

_____

Participant Name _____ **Date of Birth:** _____

Meaningful Life Activities

General

a.) Activities of Daily Living	☐ 1. Adequate	☐ 2. Needs Planning	☐ 3. Needs Intensive Support
b.) Ability to use community resources	☐ 1. Adequate	☐ 2. Needs Planning	☐ 3. Needs Intensive Support
c.) Ability to access an activity	☐ 1. Adequate	☐ 2. Needs Planning	☐ 3. Needs Intensive Support
d.) Ability to plan & organize time	☐ 1. Adequate	☐ 2. Needs Planning	☐ 3. Needs Intensive Support

e.) In-home activities and interests: _____

f.) Out-of-home activities and interests: _____

Psychosocial ***See Appendix B for Psychosocial CODES***

CURRENT Activities: Indicate all codes that apply ☐ ☐ ☐

DESIRED Activities: Indicate all codes that apply ☐ ☐ ☐

Educational/Vocational ***See Appendix B for Ed/Voc CODES***

CURRENT Activities: Indicate all codes that apply ☐ ☐ ☐

DESIRED Activities: Indicate all codes that apply ☐ ☐ ☐

Social/Recreational/Leisure ***See Appendix B for Social/Recreational CODES***

CURRENT Activities: Indicate all codes that apply ☐ ☐ ☐

DESIRED Activities: Indicate all codes that apply ☐ ☐ ☐

Current Participant Supports

a.) Does the person have any contact with family, friends, or community supports? ☐ Yes ☐ No

b.) How frequently does the person interact with family or friends? _____

c.) How long has the person been involved in the above relationships? _____

d.) Does the person indicate a desire or a willingness to engage in new relationships or activities? ☐ Yes ☐ No

***Please share any additional information regarding the individual's needs that you think would help in determining case management, residential, or other supportive services.**

Participant Name _____ **Date of Birth:** _____

The following questions are required for application to Mental Health Residential Services only.

Housing Preferences. Please describe the type of living situation in which the person would most want to live.

a.) *Is this living situation alone or shared with someone? ☐ Alone ☐ Shared ☐ Either

b.) If shared, is there someone in mind with whom the person would like to live? Who is that? _____

c.) *Has the person lived alone in an independent setting? ☐ Yes ☐ No When was this? _____

d.) *\Would the person prefer to live in a group setting where meals and other supports are provided? ☐ Yes ☐ No

e.) Please add any additional information about the person's treatment _____

_____

_____

Housing Preference, cont'd.

***In what area(s) of Philadelphia would the person like to live? (In parentheses are some of the neighborhoods in these areas). Indicate willingness (without order) by checking a box for an area. Please make at least two selections.**

☐ **North Philly** (Franklintown, Callowhill, Spring Garden, Poplar, Northern Liberties, Fairmount, Francisville, Brewerytown, Yorktown, Ludlow, North Central, Temple, Strawberry Mansion, Hartranft, Fairhill, Allegheny West, Tioga, Hunting Park, Nicetown)

☐ **Kensington/Port Richmond** (Fishtown, Kensington, Port Richmond, Juniata Park, Bridesburg)

☐ **Northeast** (Frankford, Tacony, Rhawnhurst, Mayfair, Fox Chase, Torresdale, Bustleton)

☐ **Center City** (Logan Circle, Chinatown, Old City, Rittenhouse Square, Washington Square)

☐ **Southwest** (SW Schuylkill, Bartram, Mount Moriah, Paschall, Elmwood Park/Clearview)

☐ **West** (University City, Powelton, Mantua, Belmont, Spruce Hill, Walnut Hill, Mill Creek, Parkside, Cedar Park, Cobbs Creek, Wynnefield, Overbrook, Carroll Park, Overbrook)

☐ **South Philly** (Grays Ferry, Bella Vista, Queen Village, Point Breeze, Pennsport, Tasker, Snyder, Girard Estate, Marconi Plaza, East Oregon)

☐ **Northwest** (Wissahickon, Manayunk, Roxborough, Andorra, East Falls, Germantown, Wister, Mt. Airy, Chestnut Hill, Feltonville, Olney, Logan, Fern Rock, Oak Lane, Cedarbrook, Ivy Hill)

CITY OF PHILADELPHIA
DEPARTMENT OF BEHAVIORAL HEALTH and INTELLECTUAL DISABILITY SERVICES (DBHIDS)
AUTHORIZATION TO OBTAIN, USE AND DISCLOSE HEALTH INFORMATION

Name:	SSN:	
Current Location:	Contact Name:	Phone #:
Address:	Date of Birth:	SID/PP#:
Dates of Treatment:		

I have participated in the preparation of the attached application for residential services and I authorize the City of Philadelphia, Department of Behavioral Health to obtain, use or disclose the following health information:

☐ Application for Transitional Housing ☐ Application for Permanent Supported Housing

☐ Medical Evaluation (MA-51) ☐ Targeted Case Management

☐ Psychiatric Evaluation

☐ Criminal Assessment Form ☐ PCPC / ASAM

For the purpose ☐ Continuity of Care and Treatment Coordination

☐ Other: _____

I have been informed that I have the right to withdraw permission in writing at any time. I understand that my withdrawal of permission does not apply to information that was already released, used or shared. _____ (Initial)

This authorization is valid for one year from the date of signature.

I understand that this information may be re-released.

I understand that Targeted Case Management is a voluntary, time-limited service provided to assist me.

I have been informed of my right, subject to Section 7100.111.3 of the Pennsylvania Mental Health Procedures Act and subject to the Pennsylvania Drug and Alcohol Abuse Control Act, to inspect the material to be released.

This form has been fully explained and I understand its content.

Signature of Client 14 years or older:		Date:
Signature of Parent or Person Authorized in lieu of Parent:		Date:
Relationship to Client:		
Witnessed by:	Title:	Date:

Verbal Consent: If the client or parent is unable to provide a signature, the following two witnesses attest that the client or parent understood the nature of this release and freely gave verbal consent.

Verbal consent was freely given by _____

On _____ as witnessed by: _____

Signature of Witness:	
Title or Relationship:	Date:
Signature of Witness:	
Title or Relationship:	Date:

City of Philadelphia
Department of Behavioral Health/Mental Retardation Services
Criminal History and Needs Assessment

Client _____ Alias _____ DOB _____ Sex _____

SS # _____ PP# _____ Client's present location _____

Has the client been on a psychiatric unit during this incarceration? ☐ No ☐ Yes If "Yes", dates _____

Placement/Address prior to Incarceration _____

Current Criminal Charges or Convictions:	Status: Preliminary Arraignment	Pre-Trial	Sentenced	Other	If Sentenced: Minimum DATE	Maximum DATE
_____	☐	☐	☐	☐	_____	_____
_____	☐	☐	☐	☐	_____	_____
_____	☐	☐	☐	☐	_____	_____

Does the client have any outstanding Court Orders? Yes ☐ No ☐ If so, a copy must accompany this referral.

Court stipulations/Conditions of Probation/Parole

_____

Past convictions (include Charge and Year of conviction)

_____ _____ _____

_____ _____ _____

Does the Client have a history of sexual convictions? ☐ Yes ☐ No ☐ Unknown If Yes, Dates _____

(SCIs only) Is Client registered vis a vis Megan's Law? ☐ Yes ☐ No ☐ Unknown

Circumstances of convictions (brief description)

_____

_____

Outstanding Detainers (Type/Jurisdiction)

_____

_____

Violation of Probation/Parole Detainers

Original conviction	Date adjudicated
_____	_____
_____	_____

Institutional Infractions during incarceration _____

_____

Status			County	State	Officer	Phone	Exp Date
Probation	☐ Active	☐ Not active	_____	_____	_____	_____	_____
Parole	☐ Active	☐ Not active	_____	_____	_____	_____	_____

Criminal History and Needs Assessment

Special needs (e.g., wheelchair-bound, hearing- or vision-impaired, clothing) _____

CLINICAL ISSUES: SUBSTANCE ABUSE and MENTAL HEALTH NEEDS

D&A treatment history: Details (dates, locations, circumstances) _____

Treatment during this incarceration _____

Client has expressed interest in post-release treatment ☐ No ☐ Yes

MH treatment history: Details (dates, locations, circumstances) _____

Treatment during this incarceration _____

Client has expressed interest in post-release treatment ☐ No ☐ Yes

Clinical impressions (regarding Client's attitudes, compliance, gender issues, etc.) _____

Active Restraining Order: ☐ No ☐ Yes Details: _____

History of Homelessness ☐ No ☐ Yes Details: _____

Other Referrals:

☐ **FIR**	☐ Pending	☐ Accepted	☐ Rejected	☐ **IPP**	☐ Pending	☐ Accepted	☐ Rejected
☐ **FOCIS**	☐ Pending	☐ Accepted	☐ Rejected	☐ **TCM**	☐ Pending	☐ Accepted	☐ Rejected
☐ **TC**	☐ Pending	☐ Accepted	☐ Rejected	☐ **AAS**	☐ Pending	☐ Accepted	☐ Rejected
☐ **Other**							

Submitted by:

Name: _____ Phone: _____ Beeper: _____ Fax _____

Signature: _____ Position: _____ Date: _____

PSYCHIATRIC EVALUATION

PLEASE COMPLETE LEGIBLY

NAME OF PERSON	D. O. B.	DATE

DIAGNOSES (List Behavioral Health diagnoses first):	DSM-5 # *or* ICD10 #

REASON FOR EVALUATION: **SITE OF EVALUATION:**

PSYCHIATRIC HISTORY

Onset of Psychiatric Illness (If Known):

First Hospitalization (where/when): **Most Recent Hospitalization (where/when):**

IF Outpatient Treatment only, First: **Most Recent Outpatient Treatment:**

Current Source of Treatment

◯ **MH Outpatient** **Case Management** ◯ **Assertive Community Treatment (ACT)** ◯ **Support**

◯ **Community Integration Recovery Center (CIRC)** ◯ **TBD** ◯ **Other:** _____

Current Symptoms

_____

_____

_____

Personal Appearance: Grooming: **Nutrition:** **Abnormal movements:**

Alertness: **Orientation:** **Person –** **Place -** **Time -**

Concentration: **Memory:** **Speech:**

Mood: **Affect:** **Insight:** **Judgements:**

Delusions: **Hallucinations:**

Suicidality: (specify) **Homicidality: (specify)**

CURRENT MEDICATIONS: NAME	DOSAGE AND FREQUENCY	CURRENT MEDICATIONS: NAME (Continued)	DOSAGE AND FREQUENCY

RECOMMENDATIONS/COMMENTS:

_____

_____

_____

_____

_____

PSYCHIATRIST'S NAME PRINTED	PSYCHIATRIST'S SIGNATURE	AGENCY	TELEPHONE#	DATE

MEDICAL EVALUATION

THIS FORM MUST BE COMPLETE AND PRINTED LEGIBLY TO BE PROCESSED.

NAME	D.O.B.	AGE	SEX

MEDICAL HISTORY (INCLUDE SURGICAL PROCEDURES, DRUG AND ALCOHOL TREATMENT, AND CURRENT MEDICAL PROBLEMS):
N.B. If diagnosed with diabetes, describe the person's ability to self-test and administer treatment.

HAVE YOU EVER USED THE FOLLOWING: **CHECK HERE IF "NOT APPLICABLE" OR "NONE"** ☐

	YES	CURRENT FREQUENCY OR DATE OF LAST USE		YES	CURRENT FREQUENCY OR DATE OF LAST USE
ALCOHOL			COCAINE		
MARIJUANA			OTHER DRUG(S) *(SPECIFY)*		
CIGARETTES					

FAMILY HISTORY: **CHECK HERE IF "NOT APPLICABLE" OR "NONE"** ☐

	YES	YOURSELF	FAMILY MEMBER *(RELATIONSHIP)*		YES	YOURSELF	FAMILY MEMBER *(RELATIONSHIP)*
DIABETES				CANCER			
HEART ATTACK				TUBERCULOSIS			
STROKE				BLOOD DISORDER			

CHECK ALL OF THE SYMPTOM(S) YOU'VE HAD DURING THE PAST YEAR: **CHECK HERE IF "NOT APPLICABLE" OR "NONE"** ☐

DURING THE PAST YEAR HAVE YOU EVER HAD THE FOLLOWING SYMPTOMS: *(CHECK THOSE THAT APPLY)*

☐ HEADACHES	☐ HEARING PROBLEMS	☐ PERSISTENT TIREDNESS	☐ HYPERTENSION
☐ DIZZINESS	☐ NOSE BLEEDS	☐ UNANTICIPATED WEIGHT GAIN OF MORE THAN 20 LBS.	
☐ BLOOD IN STOOLS	☐ PERSISTENT COUGH	☐ UNANTICIPATED WEIGHT LOSS OF MORE THAN 20 LBS.	
☐ VISION PROBLEMS	☐ A SORE THAT HAS NOT HEALED	☐ CHEST PAIN/TIGHTNESS	

MEDICAL EXAMINATION	HEIGHT	WEIGHT	BLOOD PRESSURE	TEMPERATURE	PULSE RATE	CBC

CHECK IF "ABNORMAL" OR IF MONITORING IS NEEDED **CHECK HERE IF "NOT APPLICABLE" OR "NONE"** ☐

EYES	☐ MUSCULOSKELETAL	☐ ABDOMEN	☐ NECK	☐ MOUTH
☐ OD/	☐ EARS	☐ SKIN	☐ NERVOUS SYSTEM	☐ VEINS
☐ OS/	☐ LUNGS	☐ NOSE	☐ THROAT	☐ ANAL-RECTAL
☐ BREAST	☐ GYN	☐ HEART	☐ ARTERIES	☐ LIVER
☐ EXTREMITIES	☐ LYMPH NODES	☐ HERNIA	☐ GENITALIA	☐ KIDNEYS

PHYSICAL DISABILITIES AND/OR LIMITATIONS
CURRENT MEDICATIONS (INCLUDE "OTC")
COMMUNICABLE DISEASE(S)
RECOMMENDED DIETARY LIMITATIONS (INDICATE WHY NONE IS RECOMMENDED IF CLIENT IS DIAGNOSED OBESE)
ALLERGIES
RECOMMENDATIONS FOR STAFF AT RESIDENTIAL FACILITY

PHYSICIAN'S NAME PRINTED	PHYSICIAN'S SIGNATURE	AGENCY	TELEPHONE#	DATE

DBHIDS
DEPARTMENT of BEHAVIORAL HEALTH and INTELLECTUAL disABILITY SERVICES

C·B·H
Community Behavioral Health
A DIVISION OF DBHIDS | CBHPHILLY.ORG

APPENDIX A

TCM PROVIDERS - ADULTS

7/1/2021

	AGENCY NAME	PROGRAM NAME	ADDRESS	SERVICE TYPE/SPECIALITY	AVAILABILITY	REFERRAL OPTIONS: EMAIL	PHONE	FAX	WALK-IN	CONTACT PERSON	DESCRIPTION/SPECIALTIES
1	**CATCH,Inc.**	Adult Blended Case Management	1417 W. Oregon Ave., 2nd Floor, Phila., PA 19145	Adults-18+	Office Hours: Monday-Friday: 8:30am-5:00pm; Emergency On Call	Bsandi@catchinc.com	215-336-0477	215-336-7043	By Appt only	Bobby Sandi, Program Coordinator	We specialize in adults with mental health issues and co-occuring disorders
2	COMHAR Inc	Adult Blended Case Management	2022 East Allegheny Avenue, Philadelphia, PA 19134	Adults-18+/ Men and Women; Bi-Lingual or Spanish Speaking services are also available	Mondays - Fridays: 8:30AM - 5:00PM Emergency On Call Monday - Fridays after 5:00PM until 8:30 AM, Saturday and Sundays 24 hours on call services	camille.maxwell-nery@comhar.org	215-427-6616	215-427-1631	N/A	Camille Maxwell, BCM Director	We are Blended case management services, we offer support to clients who are suffering from a serious mental health illness, drug and alcohol use, and sometimes physical health that has proven for them to be difficult to manage on their own to be able to function within the community. Our Case Management program also offers Bi-Lingual case management services for those who are Spanish speaking.
3	Consortium	Adult Blended Case Management	137 So. 58th Street, Phila., PA 19139	Adults-18+/ Woman and Men	Office Hours: Mon- Friday: 9:00 am - 5:00 pm; On call for crises	shamid@consortium-inc.org; sberry@consortium-inc.org	267-233-5261; 215-748-8400		By Appt	Shahida Hamid, Dir/Stephanie Berry, Supv	We specializei in supporting the forensic population with transitioning from prison back into the community.
4	Hall Mercer	Adult Blended Case Management	245 S. 8th Street Philadelphia, PA 19106	Adults 18+	Office Hours: Monday-Friday: 8:00am-6:00pm; Emergency On Call	Maryanne.Bourbeau@pennmedicine.upenn.edu	Appt only (215-829-7648)	215-829-5376	By appt only	Maryanne Bourbeau, Program Manager, Maryanne.Bourbeau@pennmedicine.upenn.edu	Adults with a serious and persistent mental health diagnosis.
		ICM Access (Homeless)	246 S. 8th Street Philadelphia, PA 19106	Adults 18+	Office Hours: Monday-Friday: 8:00am-6:00pm; Emergency On Call	Maryanne.Bourbeau@pennmedicine.upenn.edu	Appt only (215-829-7648)	215-829-5376	By appt only	Maryanne Bourbeau, Program Manager, Maryanne.Bourbeau@pennmedicine.upenn.edu	Adults with a serious and persistent mental health diagnosis. Adults with a history or presence of homelessness.
		Prevention and Recovery Services (PARS)	247 S. 8th Street Philadelphia, PA 19106	Adults 18+	Office Hours: Monday-Friday: 8:00am-6:00pm; Emergency On Call	Maryanne.Bourbeau@pennmedicine.upenn.edu	Appt only (215-829-7648)	215-829-5376	By appt only	Maryanne Bourbeau, Program Manager, Maryanne.Bourbeau@pennmedicine.upenn.edu	Adults with serious and persistent mental health diagnosis. PARS is a 90-day case management program.
		Southeast Asian Blended Case Management	248 S. 8th Street Philadelphia, PA 19106	Adults 18+	Office Hours: Monday-Friday: 8:00am-6:00pm; Emergency On Call	Maryanne.Bourbeau@pennmedicine.upenn.edu	Appt only (215-829-7648)	215-829-5376	By appt only	Maryanne Bourbeau, Program Manager, Maryanne.Bourbeau@pennmedicine.upenn.edu	Adults with a serious and persistent behavioral health diagnosis who also speak Cantonese, Mandarin, Khmer, or Vietnamese.
5	**Intercommunity Action, Inc. (INTERACT)**	Adult Blended Case Management	4200 Mitchell St. Philadelphia, Pa. 19128 (Suite 1000)	Adults 18+	Mon. - Fri.: 8:30am - 5pm Emergency On-Call 24hrs	potieno@intercommunityaction.org; bgillies@intercommunityaction.org; ylewis@intercommunityaction.org	(215) 487-1330 ext. 2004	(215) 509-6507	Appt. only	Peter Otieno, TCM Director / (215) 487-1330 ext. 2004; Binti Gillies, BCM Supervisor /(215) 487-1330 ext. 2020; Yvonda Lewis, BCM Aide / (215) 487-1330 ext. 2000	Adults with serious and persistent mental health diagnosis.

	AGENCY NAME	PROGRAM NAME	ADDRESS	SERVICE TYPE/SPECIALITY	AVAILABILITY	EMAIL	PHONE	FAX	WALK-IN	CONTACT PERSON	DESCRIPTION/SPECIALTIES
6	**John F. Kennedy Behavic**	Adult Blended Case Management	112 N. Broad Street ~ Philadelphia, PA 19102	Adults-18+	Office Hours: Monday-Friday: 9:00am-5:00pm; Weekend Staff hours vary Emergency On Call	trandolph@jfkbhc.org; jeubanks@jfkbhc.org; afantozzi@jfkbhc.org	215-568-0860 ext. 3342	215-825-3701	N/A	Central Intake Unit ~ CIU; Toni Randolph, BCM Dir/trandolph@jfkbhc.org; Jeanine Eubanks, Sup/jeubanks@jfkbhc.org; Alex Fantozzi, QA Dir./afantozzi@jfkbhc.org	Community Linkage; Consistent/persistent follow up on behalf of a participant; Immediate and Effective respons in emergencies; Consumate professional and empathetic staff; Work well with all presenting challenges
7	**Mental Health Partnerships**	ACCESS / ICM (Homeless)	4950 Parkside Avenue, Suite 200, Philadelphia, PA 19131	Adults - 18+	Office Hours: Monday-Friday: 8:30am-4:30pm; Emergency On Call	**THavers@mhphope.org**	267-507-3950	215-878-1265	N/A	Teresa Havers, Division Dir	We work to improve the quality of life for homeless Philadelphians with mental health conditions, people who require assistance in coordinating shese services.
8	Merakey Philadelphia	Blended Case Management	27 E. Mt. Airy Avenue, Philadelphia, PA 19119	Adults-18+	Office Hours: Monday-Friday: 8:30am-4:30pm; Emergency On Call	Lquintana@Merakey.org	215-248-6851	215-248-6765	Appt. Only	Lisa Quintana Community Based Program Director	Blended case management for adults in Philadelphia County w supports ; team includes BCM's with mental health and substance abuse as well as forsensic specialties
9	Northeast Community Center for Behavioral Health	Adult Blended Case Management	Roosevelt Blvd. & Adams Ave.; Phila., PA 19124	Adults 18+	Office Hours: Monday-Friday: 8:00am-6:00pm; Emergency On Call	BCMreferrals@neccbh.org	n/a	215-831-2929	By Appt only	Christine Cohen & Joy Peace-Thomas, BCM Directors; BCMreferrals@neccbh.org	Chronic mental illness
10	NET Centers	Adult Blended Case Management (Mental Health/Substance Use Diagnosis)	499 N. 5th Street Suite C, Philadelphia, PA 19123	Adult 21+/Dual Dx	Office Hours: Monday-Friday: 8:00am-6:00pm; Sat, by appt; 24/7 Emergency On Call	AdultBCM@netcenters.org	(267) 348-3587	215-408-4932	Monday-Friday: 8:00am-6:00pm; Sat, by appt; 24/7	Kimberly Earl, Dir/ Kimberly.Earl@net-centers.org/ 215-408-4932	dual dx/Opioid use Disorders/forensic pop.
11	PAHrtners Deaf Services	Adult Blended Case Management	614 N. Easton Road, Glenside, PA 19038	Adults - 18+	Office Hours: Monday-Friday: 8:30am-4:30pm; 24/7 Emergency On Call	Fredrick.Barnes@rhanet.org; Jessica.lamartin@rhanet.org; Kelly.barden@rhanet.org; Edwin.urena@rhanet.org Meghan.dearnly@rhanet.org	215-884-9770 x 622; Video relay service: 1-866-327-8877	215-884-6310 g	N/A	Jessica LaMartin, Operations director	To Maximize and individual's ability to live independently in the community . We help our members access and manage medical, social, and educational services while also working on socialization and independent living skills. Serving individuals with mental health diagnosis who are also deaf or hearing impaired.
12	PATH, INC	ADULT BCM	8220 CASTOR AVE PHILADELPHIA PA 19152 Pending to: 1919 Cottman AvePhiladelphia, PA 19111	Adults 18+	M-F 8am to 6 pm; weekends 6 hrs/day; Emeregency On-Call	AdultBCMreferrals@pathcenter.org			By Appt only	MaryBeth D'Alonzo 215-728-430 dalonzo@pathcenter.org; Gail Finnel 215-728-4562 gfinnel@pathcenter.org	Specialties: Working with Young Adults; Russian speaking case manager
13	Philadelphia Mental Health Care Corporation (PMHCC CM)	PMHCC Case Management (Substance Use Diagnosis)	1601 Market St., 5th Flr. Philadelphia, PA 19103	Adults-18+/must have primary substance abuse issues; however co-occuring mild to moderate mental health issues are accepted when PMHCC-CM services are appropriate.	Office Hours: Monday-Friday: 8:00am-5:00pm; Emergency On Call	lwilliams@pmhcc.org; swilliams@pmhcc.org	For Appts only - 215-546-6435	215-790-4960	By Appt only	Lauren Williams, B.S Referral Specialist/ lwilliams@pmhcc.org; Shanay Durham, M.S Compliance and Quality Assurance Officer/ swilliams@pmhcc.org	PMHCC Case Management is a unit dedicated to providing recovery support services to individuals as they journey through their recovery process
14	RHD FaSST Connections	Resource Coodination	5201 Old York Rd Suite 103 Philadelphia PA 19141	Adult 18+	M-F 8am-5pm (NOT ON CALL)	F-CReferrals@RHD.ORG	267-331-8153	215-457-3028	Yes	Ann Ryan Director Ann.Ryan@RHD.ORG	Specialize in Homeless singles and families living in shelters
	(Shelter residents only)	Intensive Case Management	5201 Old York Rd Suite 103 Philadelphia PA 19141	Adult 18+	M-F 8am - 5pm and EMERGENCY ON-CALL	F-CReferrals@RHD.ORG	267-331-8153	215-457-3028	Yes	Ann Ryan Director Ann.Ryan@RHD.ORG	Specialize in Homeless singles and families living in shelters

APPENDIX B

DBHIDS Codes for Integrated Intake

Living Environment Codes
1 - Living Alone Independently
2 - Living With Others (Largely Independent)
3 - CRR Minimum Supervision
4 - Personal Care Home
5 - Domiciliary Care or Foster Care
6 - Living With Others (Largely Dependent)
7 - Living Alone (Largely Dependent)
8 - Supported Living
9 - CRR Moderate Supervision
10 - CRR Maximum Supervision
11 - CRR Intensive Maximum Supervision
12 - Long Term Structured Residence
13 - MR-CLA
14 - General/VA Medical/Surgical Ward
15 - Nursing Home
16 - General/VA Psychiatric Ward
17 - Inpatient/Residential D/D Program
18 - Private Psychiatric Hospital
19 - Extended Acute Care Unit
20 - State Mental Hospital
21 - Single Room Occupancy Hotel
22 - Shelter/Mission/Progressive Demand/Safe Haven
23 - Criminal Detention (SCI, County Jail, Other)
24 - Other Institutional Setting (Not Specified Above)
25 - Homeless
26 - Other Community Setting (Not Specified Above)
27 - Children's Program
28 - OSH Transitional Housing Program
29 - Drug/Alcohol Recovery House

Psychosocial Activities Codes
1 - CIRC / Transformed Day Services
2 - Outpatient – Sees Outpatient Therapist (professional)
3 - Outpatient (IOP) – Intensive Outpatient Services
4 - Medication Clinic
5 - Clubhouse – MH + Vocational
6 - Addictions - Co-occurring/Drug & Alcohol Support (Program, Service or Mutual Support Group) e.g., NA, AA, Double Trouble, Friends Connection, etc.
7 - Addictions (non- D&A) Support (Program, Service or Mutual Support Group) e.g., Gambling, OCD, Over-eating, Sexual Addiction, etc.
8 - Mental Health Support: Non-Addictions, non-professional (Program, Service or Mutual Support Group e.g., OCD, BPD, Schizophrenia, etc.)
9 - Peer Support – Peer Counseling with individual Peer Specialist
10 - Peer Support – Peer Resource Center or Drop-in Center
11 - Warmline
12 - Other
13 - None of the Above

Educational/Vocational Codes
1 - Competitive Private Sector Employment (21+ hrs/wk)
2 - Attending College (7+ credit hours) or High School
3 - Remains at home to care for Dependents
4 - Competitive Private Sector Employment (20 or less hrs/wk)
5 - Retired (age 60+)
6 - Supported Employment (21+ hrs/wk)
7 - Supported Employment (20 or hess hrs/wk)
8 - Affirmative Industry Employment (21 + hrs/wk)
9 - Affirmative Industry Employment (20 or less hrs/wk)
10 - Transitional Employment (21+ hrs/wk)
11 - Transitional Employment (20 or less hrs/wk)
12 - Attending College (6 or less credit hrs)
13 - Actively Seeking Employment
14 - Attending Vocational School or Training
15 - Basic Academic Preparation (GED)
16 - Screening and Evaluation
17 - Sheltered Employment
18 - Ongoing Volunteer Work
19 - Sheltered Workshop
20 - Prevocational Training
21 - No Vocational or Educational Activity
22 - Actively seeking Volunteer work
23 - Basic Academic Preparation (Literacy or ESL Classes)
24 - Internship
25 - Other -- Please explain on form

Social, Recreational, Leisure Activities Codes
SOLITARY ACTIVITIES
1 - Passive: (e.g., Cards, reading, television, listening to music, puzzles)
2 - Active/Creative: (e.g., Journaling, Story-writing, Drawing, Painting,
3 - Exploratory: (e.g., Pursuit of Hobbies or Other Interests)
4 - Playing an instrument, computer, cooking, scrapbooking, etc.)
5 - Relaxation & Stress Reduction – Exercises, Visualization, etc.
6 - Physical Exercise: on your own (e.g., running, yoga, Pilates, walking, weight training, etc.)
INTERACTIVE ACTIVITIES
(e.g., spending time together, movies, meals together, shared hobbies or interests, etc.)
7 - Social, Recreational, Leisure Activities with Significant Other(s)
8 - Social, Recreational, Leisure Activities with Friends
9 - Social, Recreational, Leisure Activities with Family
10 - Peer Resource Center or Drop-in Center
11 - Religious Affiliation
12 - Membership or Participation in Group Activities
13 - Physical Exercise: utilizing gym membership
14 - Team Sports Participation
15 - Other Please explain on form
16 - None of the Above

ABBREVIATIONS

AA/NA	Alcoholics Anonymous / Narcotics Anonymous	FIR	Forensic Intensive Recovery
ACT	Assertive Community Treatment	FRN	Family Resource Network
ACL	Active Caseload List	ICM	Intensive Case Management
AOD	Alcohol and Other Drugs	MA	Medical Assistance
BCM	Blended Case Management	MH	Mental Health
BHS	Behavioral Health System	MIS	Management Information System
BHSI	Behavioral Health Special Initiative	MISA	Mental Illness and Substance Abuse
BHTEN	Behavioral Health Education & Training Network	NACM	National Association of Case Managers
BSU	Base Service Unit	OAS	Office of Addiction Services - (formally known as CODAAP)
CAC	Certified Addictions Counselor	OCC	Outreach Coordination Center
CIRC	Community Integrated Recovery	OMH	Office of Mental Health
CARES	Cross Agency Response for Effective Services	OMHSAS	State of Pennsylvania Office of Mental Health and Substance Abuse Services
CBH	Community Behavioral Health	PARS	Prevention And Recovery Services
CEU	Continuing Education Units	PCP	Primary Care Physician
CIF	Individual Identification Form	PGP	Personal Goal Plan
CM	Case Management	RC	Resource Coordinator/Resource Coordination
CQI	Continuous Quality Improvement	RIM	Research and Information Management
CODAAP	Coordinating Office of Drug and Alcohol Abuse Programs - now known as OAS	RN	Registered Nurse
CPS	Certified Peer Specialist	RRT	Rapid Response Team
CRC	Crisis Response Center	BHJRS	Behavioral Health and Justice Related Services
TIP	Transitions, Integration, and Partnerships: Formerly Consumer Support Network (CSN) & Access to Alternative Services (AAS)	SEPTA	Southeastern Pennsylvania Transportation Authority
CSP	Community Support Program	SP	Significant Person/People (Family)
CST	Consumer Satisfaction Team	TA	Technical Assistance
D&A	Drug and Alcohol	TCM	(a)Targeted Case Management- All Mental Health Medicaid reimbursed case management services
DBHIDS	Philadelphia Department of Behavioral Health and Intellectual disAbility Services	MET	Mobile Emergency Team
CARES	Cross Agency Response for Effective Services	TCMU	DBHIDS Target Case Management Unit
EM	Environmental Matrix	WMP	Wellness Management Plan (formally the Relapse Prevention Plan)
EVS	Eligibility Verification System	WRAP	Wellness Recovery Action Plan
F.A.C.E.	Factual And Clinical Elements (Sheet)		

GLOSSARY

Base Service Unit (BSU)	The Philadelphia BSU system is comprised of thirteen federally mandated community mental health centers located in specified catchment areas. It is a geographically based model intended to facilitate data collection and tracking of individuals based upon their area of residence. Historically, the BSU system has also been used as a 'safety net' where people with no insurance are directed and expected to receive services.
Community Behavioral Health (CBH)	is a private, non-profit corporation operated by the City of Philadelphia serving persons with mental illness and addictions. It is the largest behavioral health managed care organization in the country devoted to serving persons on Medicaid and the only one operated by a government body.
Concurrent Review	is a semi-annual process in which the service participant's need for continuing service is assessed. Continued authorization of Targeted Case Management services is determined by CBH through the DBHIDS-TCM Unit staff following review of information submitted by the agency Targeted Case Management Team (including the Individual Information Form and Personal Goal Plan). Residential Concurrent Review is conducted by TIP Unit Program Analysis staff.
Environmental Matrix-Adults	is a scale that evaluates the functional level of individuals on six identified activities and determines the need for case management services. The scale is used by OMH-TCM staff at the time of referral for case management services (provisional score). The scale is used by agency TCM staff 1) within 30 days of authorization to TCM services, 2) whenever there is a substantial change in the individual's life and 3) at the point of concurrent review.
Intensive Case Management (ICM)	as defined in Pennsylvania Code Title 55. Public Welfare DPW Chapter 5221. Current through 27 Pa.Bulletin 6168 (November 22, 1997) 5221.3 Definitions.
Medical Necessity Criteria	are factors used to determine a person's need for TCM services. These criteria are based on the person's mental health diagnosis, level of functioning, mental health treatment history, and the Environmental Matrix.
MH Residential	Mental Health Transitional Housing Programs that were previously considered "Residential Programs" have been the foundation of a psych-rehab service delivered in congregate or clustered apartment settings. Below are listed acronyms that have been used to describe these settings;
PDR *Progressive Demand Residences*	Provides minimal level of structure for persons being discharged from a hospital or are in urgent need of temporary housing.
CRRS *Specialized CRR*	Provides CRR services with various enhancements for medical needs
RITA *Rehabilitative Intensive Therapeutic Arrangement*	Provides a comparatively structured setting. Persons referred may present greater behavioral challenges and generally need a higher client-to-staff ratio.
ICRR *Intensive CRR*	CRR services with intensive supervision, typically MH care for forensic reentry.
CRRX *Max care CRR*	CRR services with maximum supervision.
SPEC Specialized Residence	Programs that provide a wide range of enhanced MH care
CRRM Mod care *CRR*	CRR with moderate supervision
RTFA *Residential Treatment Facility-Adult*	Also known as "RINT", provides greatest need for structure or the deepest commitment amongst those with co-occurring mental health and drug and alcohol abuse issues.
CLA *Community Living Arrangement*	Provides MH care with enhancements that complement ID services.
Psycho geriatric	Provides co-occurring MH/geriatric needs. These programs generally expect clients to be 55 to 60 years or older.

GLOSSARY

SHP--Supported Housing Program	The apartments are frequently "clustered" in a single building. These programs commonly include HUD funding which requires that clients have a history of homelessness. When a client "graduates" from this program, he or she needs to find other housing arrangements (with assistance, as needed).
SIL Supported Independent Living	These apartments are commonly "scattered" throughout the city. When a client "graduates" from this program, he or she commonly remains in the apartment; the support team is simply withdrawn.
Natural Community Supports	are naturally occurring resources in the community that are available to all citizens in the community. Services and resources funded by the BHS are excluded by definition. Examples of natural community supports include religious organizations, recreation centers, family, and friends, other community members such as landlord, and neighbors, and educational programs.
Office of Addiction Services OAS (formerly known as	is a component of the Behavioral Health System operated by the Philadelphia Department of Behavioral Health and Intellectual disAbility Services. It has the responsibility of planning, funding, and monitoring substance abuse prevention, intervention, and treatment services within the City of Philadelphia.
Office of Mental Health	is a component of the Behavioral Health System operated by the Philadelphia Department of Behavioral Health and Intellectual Disabilities Services. It provides administrative, fiscal, program planning and monitoring for a comprehensive array of supplemental services for persons with mental illness such as residential and vocational services and Crisis Response Centers.
DBHIDS Targeted Case Management Unit (DBHIDS-TCM Unit)	is a unit that is dedicated to Targeted Case Management services and service provision for the Behavior Health System. The Unit is a primary support to the providers of TCM services for the Adult Mental Health individual and liaisons regularly with CBH and other OMH units to ensure quality of services to the BHS individual.
Personal Goal Plan (PGP)	is a strengths-based, individualized plan that serves as a roadmap for, and documents the provision of, TCM service. The PGP is an expression of the individual's needs and desires identified in his or her Strengths Assessment.
Blended Enhanced Case Management Model (TCM)	is an Intensive Case Management model in which the intensity of case management and frequency of individual contact vary in accordance with the individual's changing needs without altering the team of case managers. The pilot model also enhances delivery of service through the addition of a full-time consulting/treating psychiatrist, a nurse and a drug and alcohol specialist to the case management team.
Resource Coordination (RC)	as defined by Mental Health Bulletin (OMH-93-09) dated April 1, 1993 entitled Resource Coordination: Implementation.
Wellness Management Plan (WMP)	is an expansion of the Crisis Plan that includes relapse and crisis prevention interventions developed over time (the initial 90 days) with the person being served by TCM. The WMP may be a specialized Personal Goal Plan. The WMP identifies triggers, warning signs, special problems/needs and interventions/supports that have been developed with the person being served when they are in a period of stability. The plan is further developed as experience allows. The WMP may include (informal) Advance Directives.