



**CHILDREN CASE MANAGEMENT REFERRAL FORM**

Children’s Behavioral Health Case Management is a community-based service which is designed to

assist children and their families in gaining access to community agencies, services, and professionals whose functions are to provide the support, training and assistance required for a stable, safe, and healthy community life. The Department of Behavioral Health and disAbility Services has developed this referral form for Children’s Blended Case Management Services. Please use this form to submit an application for children’s case management.

For a child to qualify for Case Management, they must meet the following children Blended Case Management (BCM) medical necessity criteria:

**BCM Medical Necessity Criteria**

* Up to age 18, if in special education up to age 21
* Primary Diagnosis within DSM V
* Treatment History (Shall be established when one of the following criteria is met)**:**
	+ 6 or more days of psychiatric inpatient treatment in the past 12 months
	+ Without blended case management services would result in placement in a community inpatient unit, state mental hospital or other out-of-home placement, including foster homes or juvenile court placements;
	+ Currently receiving or in need of behavioral health services and receiving or in need of services from two or more human service agencies or public systems such as Education, Child Welfare, Juvenile Justice, etc.

**INSTRUCTIONS FOR SENDING REFERRALS TO PROVIDER AGENCIES**

* **Please complete the application in its entirety.**
* **Choose one case management provider agency to send referral**
	+ **If referral is sent to multiple providers, this may delay start of services**
* **If not typed, please print legibly, making sure the application is completed in its entirety. Illegible or incomplete forms will be returned**.
* **If email is unavailable to you, please call the provider for fax and/or mailing address.**
* **For a list of Child Case Management Provider Agencies, see the next page.**

*Submission of this application does not guarantee acceptance to a case management program. Case Management Provider will notify you within 5 days regarding status of referral*.

**Blended Case Management Providers**

|  |  |  |
| --- | --- | --- |
| **Provider Name** | **Referral E-mail Address** | **Phone Number** |
| CATCH, Inc. | Ccmrefer@catchinc.com | 215-336-8933  |
| Children Crisis Treatment Center (CCTC) | cctcbcm@cctckids.org | 215-496-0707 ext. 1189 |
| Children Crisis Treatment Center **(Abriendo Caminos)** | cctcbcm@cctckids.org | 215-496-0707- ext. 1203 |
| Children Crisis Treatment Center **(Tamaa)** | cctcbcm@cctckids.org | 215-496-0707- ext. 1203 |
| Community Council Health Systems | cbcmreferrals@cchss.org | 215-473-7033 |
| Consortium  | cbcmreferrals@consortium-inc.org | 512-748-7100 |
| Hall Mercer  | HMChildBCM@pennmedicine.upenn.edu | 215-829-6463 |
| Intercommunity Action, Inc. (INTERACT) | icacmreferral@intercommunityaction.org | 215-487-1330 ext. 2004 |
| Merakey | MerakeyChildBCM@merakey.org | 215-203-5400 |
| PaHrtners Deaf Services | Jessica.lamartin@rhanet.org  | 215-884-9770 x 660; Video relay service: 1-866- 327-8877 |
| PATH, INC | ChildrenBCMreferrals@pathcenter.org | 215-728-4602 |

**Blended Case Management Autism Providers**

**\*\*Must have an Autism Diagnosis\*\***

|  |  |  |
| --- | --- | --- |
| **Provider Name** | **Referral E-mail Address** | **Phone Number** |
| Child Guidance Resource Center (CGRC) | SWPBCM@cgrc.org | 267-713-4100 |
| NET Center | childbcm@net-centers.org  | 215-238-1426 ext. 3984 or 3980 |
| SPIN | spinbcmreferrals@spininc.org | 267-784-5003 |

Child’s Last name First name

DOB

Gender

Race

SS# MA#

MA eligible: Yes No

Parent/guardian name Relationship to child

Home address City, State, Zip

Home phone #

Cell Phone #

Emergency Contact #

Current behavioral health diagnosis(es) per DSM-5 or ICD-10:

Is parent/guardian/child in agreement with this referral is being submitted? Yes No

Person completing form Title \_ Agency

E-mail address

Phone #

Date

Please provide information based on the past 6 months:

# Psych hospitalizations \_\_ # Days in D&A rehab

# Days in psych hospital

# CRC\Police contacts

# 302 Commitments

# Days in juvenile detention

# Days in RTF placement

If child was involved in any of the above services in the past 6 months, give dates and describe why:

Is child currently in an out-of-home placement? No Yes If yes, please check off type of placement:

 Hospitalization RTF Foster care other (please explain)

Provide name of placement (agency, family member or other)

Address of placement Phone Number

Why is child in out-of-home placement?

Anticipated discharge date from out-of-home placement \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALL INFORMATION MUST BE COMPLETED, INCLUDING THE ANTICIPATED DISCHARGE DATE**

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**LIVING ENVIRONMENT (answer all questions being asked)**

1. What is current living environment? (Include: Who does the child live with, their relationship to child and how long have they lived at current residence)
2. Are there any stressors related to current living environment (Ex: chaotic living environment and why, child not properly supervised, drug infested neighborhood, home has bugs, family not able to pay their rent/mortgage, in danger of losing their home, etc.)?\_\_\_\_\_\_ No \_\_\_\_\_\_\_Yes If yes, please explain.
3. Have there been any significant changes to the living environment in the past 2 years (Example: Child moved to grandparents’ home 3 months ago, after mother passed away.)?

 No Yes, if yes please explain.

1. Are there any family members with significant needs (Provide information on family members that may have medical, behavioral health, Intellectual or Developmental Disorder, Substance Use Disorder, MR, D&A issues, etc.)? No Yes If yes, please explain.

**DHS/JJS INVOLVEMENT (answer all questions being asked)**

1. DHS involvement: none supervision custody
2. Juvenile justice system involvement: none probation JJ placement
3. If JJ placement, please select type: \_ residential community-based detention JJ foster care
4. Provide DHS/CUA social worker and/or PO name and phone #
5. Provide description of why child is involved with DHS/CUA/JJS and when involvement began

**EDUCATION (answer all questions being asked)**

Child attends: \_\_\_\_\_ not in school \_\_\_ regular education \_\_\_ special education \_\_\_ Partial hospital program Name of school/educational program Phone Number

If special education, specify type of classroom (Ex: emotional support, learning support, life skills, etc.):

 BH services receiving in school (if any): STEP \_\_\_\_\_\_\_IBHS other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provide description of behavior and needs for child in educational setting (Provide information on undesirable behaviors as well as positive behaviors):

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**MEDICAL ISSUES/PHYSICAL DISABILITIES/MEDICATION (answer all questions being asked)**

1. Describe child’s medical issues.
2. List all medications, any medication issues or concerns. List whether or not child/family is compliant. Give the name and contact information of prescribing physician.

**COMMUNITY/SOCIAL/PEER RELATIONS & STRENGTHS & STRESSORS**

1. Provide list of involved and supportive people in the child’s life.
2. Is child involved in community programs? No \_ Yes If yes, please list.
3. How does this child manage in the community, with peers and family?
4. What are this child’s stressors?

**NEED FOR BCM SERVICES (answer all questions being asked)**

* What BH services is child currently receiving?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Service | Provider of serviceName and phone number | Date started | How often provided | Actively participatingIn treatment? |
|  |  |  |  |  Yes No |
|  |  |  |  |  Yes No |
|  |  |  |  |  Yes No |
|  |  |  |  |  Yes No |
|  |  |  |  |  Yes No |
|  |  |  |  |  Yes No |

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**This page must be completed**

**What current BH concerns justify this child receiving BCM services (are there acting out behaviors at home or school, suicidal ideation or attempts, etc.)? What services would you like BCM to assist with? (Provide specific behaviors)**

PLEASE SEND FORM DIRECTLY TO YOUR SELECTED PROVIDER AGENCY

**Referral will only be considered if all questions are answered completely.**

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| --- |
| **FOR PROVIDERS ONLY****CBH Authorization** |
| ID# |
| Auth# |
| Date of auth |