

HOWARD COUNTY MENTAL HEALTH AUTHORITY

9151 Rumsey Road, Suite 150
Columbia, MD 21045

Phone: 410-313-7350
Fax: 410-313-7374

CASE MANAGEMENT REFERRAL FORM

Please enclose the following information: Signed Release of Information to Howard County Mental Health Authority and Alliance, Inc.; Clinical Evaluation; hospital records; and/or psychosocial assessment.

ADULT: _____ CHILD: _____

Date: _____ SS#: _____ DOB: _____ AGE: _____

Client: _____ (Name) Emergency: _____ (Name)

(Street Address) (Relationship)

(City, State, Zipcode) (Address)

(Telephone #) (Telephone #)

Sex: Male Female

Race: African-American Caucasian Asian
Native-American Hispanic/Latino
Other: _____

Veteran: Yes No

Marital Status: Never Married Married
Separated Widowed
Divorced Common-Law

Education: < 8 yrs. 8 yrs – 12 yrs.
H.S. Grad\GED > 12 years
College Graduate Post-Graduate

Income Source: _____ \\$_
_____ \\$_

Insurance #: _____
Insurance #: _____

Employment: Full-time Part-time None
Supportive Volunteer

Date last Employed: _____ or N/A

Legal History: ____ Yes ____ No
If yes: ____

HOMELESS: Type of homeless situation:
____ Shelter _____ Streets
____ Crisis Bed _____ Jail
____ Halfway House _____ Hospital
____ Family/Friend _____ Other

1. Offense\Charge: _____

NOT HOMELESS: Type of housing:
____ Section 8 Unit _____ Assisted Living
____ Bridge Subsidy _____ Senior housing
____ Shelter + Plus Care _____ RRP
____ Family and/or Spouse _____ Friend
____ Therap. Group Home _____ Independent Apt.
____ Other: (Specify): _____

2. Currently on parole\probation: ____ Yes ____ No
Agent: _____ Phone: _____

Charge: _____

3. History of violence: ____ Yes ____ No

Please explain: _____

Reason for Referral: (Please check appropriate items listed below):

- | | | | |
|---|--|--|--------------------------------------|
| <input type="checkbox"/> Income/Financial | <input type="checkbox"/> Health Insurance | <input type="checkbox"/> Housing | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Medical Care | <input type="checkbox"/> Shelter | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Vocational | <input type="checkbox"/> Employment | <input type="checkbox"/> PRP | <input type="checkbox"/> RRP |
| <input type="checkbox"/> Children's services | <input type="checkbox"/> Senior services | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Education |
| <input type="checkbox"/> Supported Employment | <input type="checkbox"/> Food/Utility services | <input type="checkbox"/> Other: _____ | |

CLIENT NAME: _____

DOB: ____ / ____ / ____

CLINICAL INFORMATION:

CURRENT PSYCHIATRIC DIAGNOSIS	PSYCHOTROPIC MEDICATIONS (CURRENT OR PAST)
Axis I:	
Axis II:	
Axis III:	
Axis IV:	Treatment Provider: _____
Axis V: Current GAF:	Psychiatrist: _____
	Telephone #: _____

Last Hospitalization: _____ (Date) _____ (Location)
 _____ (Date) _____ (Location)

Substance Abuse History: ____ Yes ____ No
 If Yes: Drug: _____ Date Last Used: _____ Frequency: _____
 Drug: _____ Date Last Used: _____ Frequency: _____

Current drug treatment: ____ Yes ____ No Agency: _____
 Contact: _____ Phone: _____

In order to qualify for case management services, the individual must meet the following criteria: (Please check)

- A clinical evaluation that indicates the individual has a primary DSM-IV diagnosis of:
 - ____ Schizophrenia (295.10 – 295.90)
 - ____ Mood Disorder (296.30 – 296.89) Does not include Mood Disorder NOS
 - ____ Other Psychotic Disorder (297.00 – 298.90)
 - ____ Schizotypal Personality Disorder (301.22)
 - ____ Borderline Personality Disorder (301.83)
- The impairment results in the individual meeting at least (3) of the following (6) criteria on a continuing or intermittent basis for at least two years:
 - ____ Inability to maintain independent employment
 - ____ Social behavior that results in interventions by the mental health system and/or not linked to mental health services
 - ____ Inability, due to cognitive disorganization, to procure financial assistance to support living in the community (housing, food, income)
 - ____ Severe inability to establish or maintain a personal support system
 - ____ Need for assistance with basic living skills
 - ____ Transitioning from one level of care to another
- Meets (1) of the following criteria: (ADULTS ONLY) (CHILDREN ONLY)
 - ____ At risk of going into, or will be released from, an inpatient hospital stay _____ Inpatient psychiatric treatment
 - ____ Homeless and/or at risk of homelessness _____ Treatment in a Residential Treatment Center (RTC)
 - ____ Living in a Shelter Plus Care Unit and/or Bridge Subsidy Unit _____ An out-of-home placement due to multiple life stressors
 - ____ Released from a detention center/jail/prison _____ Other: (Specify): _____
 - ____ Other: _____

Referral Person: _____ Agency: _____

Phone #: _____ Fax #: _____

DO NOT WRITE BELOW THIS LINE. CSA USE ONLY

CSA AUTHORIZATION:

AUTHORIZATION REQUEST FORM: _____ APPROVED _____ DENIED
 (CSA HAS COPY OF THE FORM)

RECEIVED BY CSA: ____ / ____ / ____ FORWARDED ON: ____ / ____ / ____

HCMHA STAFF: _____ DATE: _____

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Authorization of Disclosure for Case Management Services

I, _____, give my consent for the release of the following written information from _____ to the Howard County Mental Health Authority and Alliance, Inc. for the purpose of a case management referral.

_____ Annual Assessment	Other:
_____ Psychosocial Assessment	_____ Substance Abuse History
_____ Psychiatric Evaluation	_____ Legal History
_____ Psychological Testing, if available	_____ Service Plan
_____ Current Treatment Plan and Recommendation	_____ Financial\Income\Insurance
_____ Physical	_____ Admission Summary
_____ Current Medications	_____ Discharge Summary

Prohibition of Redisclosure: This information has been disclosed to us from your records whose confidentiality is protected. Any further disclosure is prohibited. This disclosure of information is effective until _____.

Signature of Applicant: _____ Date: _____

Witness: _____ Date: _____

Relationship of Witness: _____

Parent/Legal Guardian: _____ Date: _____
(if applicable)

Please return information to:

The Howard County Mental Health Authority
9151 Rumsey Road, Suite 150
Columbia, MD 21045-1994
(410) 313-7350 Fax (410) 313-7374

Revised: 08\01\06

MAIN OFFICE:

7701 Wise Avenue, Suite 206
Baltimore, MD 21222-3228

(410) 282-5900
TDD: (410) 282-0613
FAX: (410) 282-3083



Rehabilitation . . . Achievement . . . Independence.

BRANCH OFFICE:

10632 Little Patuxent Parkway
Columbia, MD 21044

(410) 992-4994
FAX: (410) 992-0180

Verification of Diagnosis

_____ is receiving case management services through the Alliance, Inc. Case Management Program.

Diagnosis: (please include the DSM-IV codes)

AXIS I:

AXIS II:

AXIS III:

AXIS IV:

AXIS V (GAF SCORE):

Signature/Credentials* _____

Date: _____

Provider Number: _____

Comments:

***Must be a licensed clinician in order to sign off on consumers diagnosis.**