

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

ADULT: \_\_\_\_\_ CHILD: \_\_\_\_\_

Date: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_

Client: \_\_\_\_\_ Emergency: \_\_\_\_\_  
(Name) (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: \_\_\_\_\_ \\$ \_\_\_\_\_  
\_\_\_\_\_ \\$ \_\_\_\_\_

\_\_\_\_\_ Medical Assistance \_\_\_\_\_ PAC (Primary Adult Care)  
\_\_\_\_\_ Medicare \_\_\_\_\_ Uninsured (No 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):

- Income/Financial  Health Insurance  Housing  Legal
- Mental Health  Medical Care  Shelter  Medications
- Vocational  Employment  PRP  RRP
- Children's services  Senior services  Substance Abuse  Education
- Supported Employment  Food/Utility services  Other: \_\_\_\_\_

CLIENT NAME: \_\_\_\_\_

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

CLINICAL INFORMATION:

CURRENT PSYCHIATRIC DIAGNOSIS (DSM IV)	PSYCHOTROPIC MEDICATIONS (CURRENT OR PAST)
Axis I:	
Axis II:	
Axis III:	
Axis IV:	Treatment Provider: _____
Axis V: Current GAF:	Therapist/Clinician: _____
	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: \_\_\_\_\_

A participant is eligible for mental health case management services if the recipient has or is eligible for Maryland Medical Assistance.

- 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 participant meets at least ONE of the following conditions:
  - \_\_\_\_ The participant is not linked to mental health and medical services
  - \_\_\_\_ The participant lacks basic supports for shelter, food, and income
  - \_\_\_\_ The participant is transitioning from one level of care to another level of care
  - \_\_\_\_ The participant needs case management services to maintain community-based treatment and services
- ADULT participant has a serious and persistent mental health disorder and is:
  - \_\_\_\_ In, at risk of, or needs continued community treatment to prevent INPATIENT PSYCHIATRIC TREATMENT
  - \_\_\_\_ At risk of, or needs continued community treatment to prevent being HOMELESS
  - \_\_\_\_ At risk of INCARCERATION or who will be released from a DETENTION CENTER OR PRISON
- CHILD/ADOLESCENT participant has a serious emotional disturbance and is in, at risk of, or needs continued community treatment to prevent:
  - \_\_\_\_ INPATIENT PSYCHIATRIC TREATMENT
  - \_\_\_\_ Treatment in a RESIDENTIAL TREATMENT CENTER (RTC)
  - \_\_\_\_ An out-of-home placement due to multiple mental health stressors

Referral Person: \_\_\_\_\_ Agency: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE. CSA USE ONLY**

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RECEIVED BY CSA: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ FORWARDED ON: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

HCMHA STAFF: \_\_\_\_\_ DATE: \_\_\_\_\_

\_\_\_\_ LEVEL I – GENERAL \_\_\_\_\_ LEVEL II – INTENSIVE

ASO AUTHORIZATION #: \_\_\_\_\_

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Columbia, MD 21045

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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.

- |  |   |
|--|---|
| <input type="checkbox"/> Annual Assessment                         | <input type="checkbox"/> Substance Abuse History    |
| <input type="checkbox"/> Psychosocial Assessment                   | <input type="checkbox"/> Legal History              |
| <input type="checkbox"/> Psychiatric Evaluation                    | <input type="checkbox"/> Service Plan               |
| <input type="checkbox"/> Psychological Testing, if available       | <input type="checkbox"/> Financial\Income\Insurance |
| <input type="checkbox"/> Current Treatment Plan and Recommendation | <input type="checkbox"/> Admission Summary          |
| <input type="checkbox"/> Physical                                  | <input type="checkbox"/> Discharge Summary          |
| <input type="checkbox"/> Current Medications                       | <input type="checkbox"/> Other: (Specify):          |

**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

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## VERIFICATION OF PSYCHIATRIC DIAGNOSIS(ES) FOR CASE MANAGEMENT REFERRALS

This form is used for the purpose of obtaining the psychiatric diagnosis(es) for a consumer who desires to be referred for Mental Health Case Management Services. This information will be used to determine the consumer's eligibility for Mental Health Case Management Services.

**NAME:** \_\_\_\_\_ **SS#:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**PROVIDER:** \_\_\_\_\_

**PHONE #:** \_\_\_\_\_

AXIS I: \_\_\_\_\_

AXIS I: \_\_\_\_\_

AXIS II: \_\_\_\_\_

AXIS II: \_\_\_\_\_

AXIS III: \_\_\_\_\_

AXIS IV: \_\_\_\_\_

AXIS V: GAF (CURRENT): \_\_\_\_\_

**NAME OF PROVIDER:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_  
*(Include credentials of provider)*

**DATE:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_