ALLEGANY COUNTY MENTAL HEALTH CASE MANAGEMENT PROGRAM
Child and Adolescent Initial Referral and Intake Form

Participant: ___________________________ Phone: ________________ DOB:________

Address: ____

Medicaid #: ________________________ SS#: __________________Sex: __ Marital Status: __

Parent: ____________________________ Legal Guardian: _________________________

Reason for Referral: ____

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Referral Date: ___________ Referring Agency: __________________________________

Contact Person: ______________________________Contact#: ______________________

Diagnosis:

Axis I ____
Axis II ____
Axis III ____
Axis IV ____
Axis V ___________

Provider Making Diagnosis___________________ Date of Diagnosis_______________
Based on the above information, ____________________________, has been determined eligible for Case Management Services, ____Yes ____ No, as of __________.

One of the following criteria must be met for services:

Children and adolescents, referred to as minors, with serious emotional disorders diagnosed according to a current diagnostic and statistical manual of the American Psychiatric Association that is recognized by the Secretary and is in, or at risk of, or needs continued community treatment to prevent:

____ To prevent inpatient psychiatric treatment;

____ Treatment in a Residential Treatment Center(RTC); or

____ An out of home placement due to multiple mental health stressors.

One of the following criteria must be met for services:

____ Not linked to mental health and medical services;
____ Lacks basic supports for shelter, food, and income;
____ Transitioning from one level of care to another level of care; or
____ Needs to maintain community-based treatment and services.

One of the following criteria must be met for General Services:

____ Has been discharged from a state mental hospital in the past 90 days.
____ Has been discharged from a mental health residential treatment facility within the last 12 months.
____ Has had more than one admission to a crisis stabilization unit(CSU), short-term residential facility(SRT), inpatient psychiatric unit, or any combination of these facilities within the last 12 months;
____ Is experiencing long-term and/or increasing acute episodes of mental impairment that may put him or her at risk of requiring intensive level of services.

One of the following criteria must be met for Intensive Services (Medicaid clients only):

____ Has been discharged from a state mental hospital in the past 30 days.
____ Has demonstrated a need for increased services from the General Level.
____ Has resided in a state mental hospital for at least 2 months in the past 24 months:
____ Resides in the community and has had two or more admissions to a psychiatric hospital in the past 12 months;
____ Resides in the community and has had five or more admissions to a crisis stabilization unit(CSU), short-term residential facility(SRT), inpatient psychiatric unit, or any combination of these facilities within the past 12 months;
____ Resides in the community and, and due to a serious mental illness, exhibits behaviors or symptoms that could result in long-term hospitalization if intensive interventions for an extended period of time or not provided.
____ Has resided in a state mental hospital for at least 6 months in the past 24 months

Primary Care Provider: ☐ Tri-State CHC ☐ Other ______________________________

Additional Comments: (Please provide as much information as possible)

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Case Management Program Only:

Based on the above information, ____________________________, has been determined eligible for Case Management Services, ____Yes ____No