PLEASE FORWARD REFERRALS TO:

ACHIEVEMENT CENTER
C/O BLENDED CASE MANAGEMENT
2420 WEST 23rd STREET SUITE 100

BCMREFERRALS@ACHIEVEMENTCTR.ORG
CONTACT PERSON: KELLY ENGLISH
PHONE: 814-459-2755 814-566-7233
FAX: 814-456-4873

BLENDED CASE MANAGEMENT
CHILD AND ADOLESCENT REFERRAL FORM

DATE:	CONSUMER'S NAME:	MCI #:	SS#:	DOB:
	PARENT/GUARDIAN:			

ADDRESS:		CITY:	STATE:	ZIP:
PHONE:	OTHER PHONE:			

INSURANCE: ☐ MA (CCBHO) ☐ MA HIPP ☐ BASE FUNDED ☐ PRIVATE INSURANCE:

MA ID#: ____

REASON FOR REFERRAL:

AGENCY REFERRING:	☐ MILLCREEK HOSPITAL ☐ ECCM ☐ OTHER:	PERSON COMPLETING REFERRAL:	PHONE :

MEDICAL NECESSITY CRITERIA: ***Attach Psychiatric or Psychological evaluation for verification of diagnosis***

1. DIAGNOSIS: Please attach a Psychiatric Evaluation verifying the diagnosis.				
Axis I: (Primary)	**Axis I CODE:** ______._____		**Axis III:**	
Axis I: (Secondary)	**Axis I CODE:** ______._____		**Axis IV:**	
Axis II:			**Axis V: (GAF)**	

2. TREATMENT HISTORY: Check all that apply and include dates where appropriate. Attach all supporting documents where required.			
☐	**6 or more days of psychiatric inpatient in the past 12 months. Include hospitals and dates:**	☐	**At risk for out of home placement without BCM**
☐	**Currently receiving or in need of mental health services from 2 or more human service agencies or public systems such as: Special education, Children & Youth, Juvenile Justice, etc. Please include names of agencies and & worker contact information in the right hand box.**	**Agency:** **Worker name & phone #:** **Agency:** **Worker name & phone #:**	
☐	**Children recommended for mental heath services by a Multi-Service Children's Team e.g. ISPT (please include documentation which includes recommendation for BCM)**		
☐	**Parent has SMI Diagnosis (please include diagnosis and supporting documentation):**		

3. FUNCTIONING LEVEL	
☐	**Global Assessment of Functioning Scale ratings or 70 and below**

Signature of Person Completing Referral: ____________________________ **Date:** __________

Signature of Physician/Licensed MH Professional: ______________________ **Date:** __________

Signature of ECCM Staff: ______________________ **Degree:** ____________ **Date:** __________

PLEASE INDICATE ANY NEEDS IN THE FOLLOWING DOMAINS

HOUSING/LIVING DOMAIN

☐ Child/adolescent/family has had stable housing < than 6 months.
☐ Child/adolescent/family is unable to access housing or to maintain current housing.
☐ Child/adolescent is at imminent risk of out-of-home placement.
☐ Child/adolescent has been home from an out of home placement:
☐ < 6 months ☐ < 12 months ☐ > 12 months

EDUCATIONAL/VOCATIONAL DOMAIN

☐ Child/adolescent/family needs or requests help in locating and gaining access to vocational/educational services.
☐ Child/adolescent’s behavior places him/her at risk of more restrictive educational placement.
☐ Child/adolescent has excessive truancy, which may result in legal action.
☐ Other identified need:

INCOME/BENEFITS DOMAIN

☐ Child/adolescent/family/representative payee has insufficient income/benefits to meet needs.
☐ Child/adolescent/family/representative payee is at risk of losing income/benefits.
☐ Child/adolescent/family/representative payee requires assistance to manage funds effectively.
☐ Other identified need:

MENTAL HEALTH TREATMENT DOMAIN

☐ Child/adolescent/family needs assistance to access and maintain mental health services.
☐ Child/adolescent/family member’s mental health symptoms/behaviors interfere with daily functioning:
☐ moderately ☐ severely
☐ Child/adolescent/family member’s mental health symptoms/behaviors interfere with family keeping mental health appointments or necessitate a more restrictive/intensive style of intervention.
☐ Other identified need:

ALCOHOL/SUBSTANCE TREATMENT DOMAIN:

☐ Child/adolescent/family member’s use of substances interferes with daily functioning.
☐ moderately ☐ severely
☐ Other identified need:

SOCIALIZATION/SUPPORT DOMAIN

☐ Mental health symptoms and/or behaviors interfere with the development of social network supports.
☐ Child/adolescent has not developed age appropriate social skills.
☐ Child/adolescent/family needs or requests assistance in linking with social opportunities.
☐ Other identified need:

BASIC ACTIVITIES OF LIVING DOMAIN

☐ Child/adolescent is unable or refuses to complete basic activities of daily living.
☐ all ☐ some
☐ Child/adolescent/family requires assistance with living in the community.
☐ Other identified need:

MEDICAL/PHYSICAL TREATMENT DOMAIN

☐ Child/adolescent/family is unable to access or maintain medical services.
☐ Child/adolescent/family member has a medical condition that requires assistance with effective communication, service coordination, or advocacy with healthcare providers.
☐ Other identified need: