Case Management Program Referral

Partnership Development Group

Fax: 410.987.3154

Partnership Development Group

Fostering community integration for individuals with disabilities

To efficiently process referrals, please fill out this form in its entirety, sign, and date.

Date: _______/_______/_______ Consumer Name: ____

SS#: ______-_____-______ DOB: _______/_______/_______ Gender: _________ Race: ______________________

Street Address: ____

City: ______________________________ State: ______ Zip: ____________ County: ____________________

Phone (Home): _________________________________ (Work/Mobile): ______________________________

Physical Description: _______________________________________ Highest Grade Completed: ___________

Emergency Contact (Relationship to Consumer):____

Contact's Phone (Home): ________________________ (Work/Mobile): ______________________________

Current consumer status (please indicate to assist in the prioritization of referrals):

- ☐ Inpatient- projected release date: ____________________________________
- ☐ Partial Hospitalization- projected release date: __________________________
- ☐ Crisis Bed/Other crisis facility- projected release date: _____________________
- ☐ Outpatient
- ☐ Date of most recent inpatient discharge: _________________________________
- ☐ Other: ____

DSM 5 Behavioral Diagnoses:

Code(s)

Primary Behavioral Diagnosis with ICD-10 Code (primary diagnosis may NOT be substance use disorder or D.D. / intellectual disability):

____

____

DSM 5 Additional Behavioral Diagnosis:

____

____

Primary Medical Diagnosis:

____

Social Elements Impacting Diagnosis: (check all that apply)

- ☐ None
- ☐ Problems with access to health care services
- ☐ Housing problems (Not Homelessness)
- ☐ Problems related to social environment
- ☐ Educational problems
- ☐ Problems related to interaction w/legal system/crime
- ☐ Occupational problems
- ☐ Homelessness
- ☐ Financial problems
- ☐ Problems with primary support group
- ☐ Other psychosocial and environmental problems
- ☐ Unknown

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1110 Benfield Blvd.
Suite B
Millersville, MD 21108

Baltimore City
1401 Severn Street
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Baltimore, MD 21230

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Functional Assessment: ____

Definition of Problem Areas (Current Symptoms): ______________________________________

____

____

Reason(s) for seeking treatment (check all that apply):

- ☐ Linkage to community resources/community integration
- ☐ Facilitating transition from more intensive services
- ☐ Prevention/reduction of hospitalization or rehospitalization
- ☐ Coordination of current community services

Risk for Aggressive Behaviors, Suicide, or Homicide: (explain): ___________________________

____

Entitlement Information:

SSI monthly: $ ______________________ Date Active: ______________________

SSDI monthly: $ ______________________ Date Active: ______________________

Medicaid #: ______________________ Date Applied / Active ______________________

Other Income/Insurance: ____

If the consumer does NOT have medical assistance / Medicaid, he or she must meet one or more of the following criteria to qualify for services through Uninsured Eligibility Coverage:

- ☐ Currently homeless or at risk of homelessness
- ☐ Has had an inpatient hospitalization within the last three (3) months
- ☐ Has been incarcerated within the last three (3) months

I, ______________________________, refer______________________________

(Referrer's Signature) (Print Consumer's Name)

______________________________ ______________________________

(Print Referrer's Name) (Referrer's Phone Number)

Referring Agency:____