# SEALNO **Bucks County Mental Health Targeted Case Management (TCM) Referral Form**

**DONNA D. DUFFY-BELL, MA, CPRP**

***Administrator***

***County Commissioners***

**ROBERT G. LOUGHERY, *Chairman***

**CHARLES H. MARTIN, *Vice Chairman***

**DIANE M. ELLIS-MARSEGLIA, LCSW**

**COUNTY OF BUCKS**

# DIVISION OF HUMAN SERVICES

**DEPARTMENT OF**

**MENTAL HEALTH/DEVELOPMENTAL PROGRAMS**

**600 Louis Drive, Suite 101, Warminster, PA 18974**

**(215) 444-2800**

**FAX (215) 444-2890**

TCM services include:

* Partnering with people in creating and achieving their own personal goals
* Assessment and Service Planning;
* Use of Community Resources;
* Informal Support Network Building;
* Linking, Accessing and Coordinating Services;
* Monitoring of Service Delivery;
* Problem Resolution.

TCM services do not include transportation. While transportation is often a barrier to accessing services, Case Managers may help the person referred learn how to access transportation, but the service *does not* include the provision of transportation.

**ADULT PSYCHIATRIC/CHILD PSYCHOLOGICAL EVALUATION MUST BE COMPLETED**

***WITHIN THE LAST SIX MONTHS* AND ACCOMPANY THE COMPLETED REFERRAL FORM BELOW.**

The case management referral must be completed in its entirety. Please take note of all attachments that must accompany the referral as well as the time frames for each. The referral packet should be submitted to the appropriate Targeted Case Management Office (see listing below):

|  |  |  |
| --- | --- | --- |
| Lower Bucks | Penndel Mental Health Center | 2005 Cabot Boulevard West, Suite 100, Langhorne, PA 19047  267-587-2345  267-587-2368 (Fax) |
|  | Northwestern Human Services of Bucks County | 2260 Cabot Boulevard, Suite 100, Langhorne, PA 19047 215-752-5760  215-752-8243 (Fax) |
|  | Family Services Association of Bucks County | 670 Woodbourne Road, Cornerstone Executive Suites, 4 Cornerstone Drive, Langhorne, PA 19047 215-757-6916  215-757-2115 (Fax) |
| Central Bucks | Lenape Valley Foundation | 500 North West Street, Doylestown, PA 18901  215-345-5300  267-885-0803 (Fax) |
| Upper Bucks | Penn Foundation | 807 Lawn Avenue, PO Box 32, Sellersville, PA 18960  215-257-2114  215-257-4716 (Fax) |
|  |  |  |
| Serving the Entire County | Access Services (TIP Program) Transitional Age Youth (TAY) ages 14-26 | 882 Jacksonville Road, Suite 203, Ivyland, PA 18974  1-888-442-1590 x32  215-259-1974 (Fax) |

Questions related to whether or not a desired service or outcome may be provided by case management should be directed to the Director of CHIPPs Services at the Bucks County Department of MH/DP (215-444-2800) or the individual agency Case Management Department.

**Bucks County Mental Health Targeted Case Management (TCM) Referral**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Date of Referral: | | | | | | |  | | | | | BSU #: | | | |  | | | | | | | | | | CMHC#: | | | | |  | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Individual’s Name: | | | | | | | |  | | | | | | | | | | | | | | | | | | SSN#: | | | |  | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DOB: | |  | | | | | | | AGE: | | | |  | |  | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Complete Address: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | Zip: | | |  | |
|  | | | | | | | | [Complete: Street address, Town and State] | | | | | | | | | | | | | | | | | | | | | |  | | | | |
| Type of residence: (own home, CRR, Recovery House, etc.) | | | | | | | | | | | | | | | | |  | | | | | | | | | | Phone: | | | |  | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MA Access #: | | | | | |  | | | | | | | | Private Insurance: | | | | | | | Y  N | | | | | | | | Medicare: | | | | Y  N | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Parent(s)/Guardian’s Name: | | | | | | | | |  | | | | | | | | | | | | | | | Relationship: | | | | | | | |  | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| C&Y Involvement: | | | | | | | | Y  N | | | Contact Person: | | | | | | | |  | | | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Axis I Diagnosis(s): | | | | | | | |  | | | | | | | | | | | | | | | DSM IV Code(s): | | | | | | | | |  | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Axis II: | | |  | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Axis III: | | |  | | | | | | | | | | | | | | | | | | | | | GAF: | | | |  | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Axis IV: | | |  | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Psychiatrist: | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Therapist: | | | |  | | | | | | | | | | | | | | Phone #: | | | | | | |  | | | | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Primary Doctor: | | | | | | |  | | | | | | | | | | | | | Phone #: | | | | |  | | | | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medical Condition(s): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Psychiatric Medications: [List all current Brand/Generic/Mg/Dose] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| List Psychiatric Hospitalizations within the last 12 months: [List hospital, dates of admission & dates of discharge] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Is There a Current Crisis Plan: | | | | | | | | | | Y  N | | | | | (If Yes Attach Copy) | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Reason for TCM Referral: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Obtain/Maintain Benefits (Medical, MH, D&A, etc…) | | | | | | | | | | | | | | | | |  | | | | Obtain/Maintain Housing | | | | | | | | | | | | |
|  | Linkage/Coordination of Services | | | | | | | | | | | | | | | | |  | | | | Linking to Community Resources | | | | | | | | | | | | |
|  | Educational Support | | | | | | | | | | | | | | | | |  | | | | Vocational Support | | | | | | | | | | | | |
|  | Increasing Informal Supports | | | | | | | | | | | | | | | | |  | | | | Other: | | | |  | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | Other: | | | |  | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Other Special Needs or Concerns:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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**Services and Supports Currently In Place**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **MH/DP** | | | **Drug & Alcohol Treatment** | | | | | **Other** | | |
|  | Medication Management Only | |  | Medication Treatment | | | |  | C&Y | |
|  | Outpatient | |  | Rehab | | | |  | Health Connections | |
|  | Partial Hospital Program-PHP/ | |  | Half Way House | | | |  | Criminal Justice Involvement | |
|  | Transitional Outpatient-TOP | |  | Outpatient/ Intensive Outpatient-IOP | | | |  | Other: |  |
|  | BCM/RC | |  | AA | | | | | | |
|  | Supports Coordination | |  | NA | | | | | | |
|  | CTT/ACT/FACT | |  | Other: |  | |  | | | |
|  | Peer Support | | | | | | | | | |
|  | Supported Employment | | | | | | | | | |
|  | Psych Rehab | | | | | | | | | |
|  | | |  | | | | | | | |
| **For Children Only** | | | | | | | | | | |
|  | Hi Fidelity Family Teams (HiFi) | | | | | | | | | |
|  | BHRS (Wraparound) | | | | | | | | | |
|  | Family Based | | | | | | | | | |
|  | Multi-Systemic Therapy (MST) | | | | | | | | | |
|  | Residential Treatment Facility (RTF) | | | | | | | | | |
|  | | | | | | | | | | |
| **Person’s Strengths, Interests & Talents:** | | | | | | | | | | |
|  | | | | | | | | | | |
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|  | | | | | | | | | | |
| **Are there any safety/risk concerns of which TCM needs to be aware:** | | | | | | Y  N | | | | |
| If Yes please specify: | |  | | | | | | | | |

**Social Supports**

|  |
| --- |
| Please List Who Provides Support in the Person’s Life (family, friends, etc.): |
|  |
|  |
|  |
| List Community Involvement: |
|  |

**Employment/Volunteer/Education**

|  |
| --- |
| List Current Employment/Volunteer Activities: |
|  |

**Transportation Resources**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Has A Car |  | Takes Public Transportation |
|  | Family/Natural Support System Drives |  | Willing To Learn Public Transportation System |
|  | Bucks County Transport (BCT) |  | |

##### TCM (ICM/RC) services were explained to the individual and individual agrees to referral for TCM

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Referred By: |  | | | Title/Position: | | |  | | | | Date: |  | | |
|  | | | | | | | | | | | | | | |
| Agency Affiliation: | |  | | | Department: |  | | Phone# | |  | | | ext. |  |
|  | | | | | | | | | | | | | | |
| **Applicant’s Signature**: | | |  | | | | | | **Date**: | | |  | | |