Form Instructions

NOTE: Only one service can be requested at a time. Please select either Enhanced Clinical Service Coordination, or Integrated Dual Disorders Treatment.

1. The referral source should complete this form for any new referral. All sections of this document must be thoroughly completed and legible in order to make a determination of services. Items should not be left blank- please indicate N/A where appropriate. Also, a current psychiatric evaluation and a list of the most recent medications must be faxed with the referral.

2. The signature of the person being referred is required indicating that they understand that a referral is being made. The signature must be no more than 30 days from the date of the referral. If the person is unable to sign, the referral source must state if it is due to current symptoms, physical limitations, or other. Also include the name and phone number of the person who discussed the referral with the individual being referred.

3. Fax the completed referral to Community Care at: 1-888-251-0087. For questions regarding the referral process, contact Community Care by phone at 1-888-251-2224.

After Form Submission

1. Referrals will be reviewed by Community Care for Medical Necessity Criteria. Referrals for county funded persons will be forwarded to a designated Allegheny County Office of Behavioral Health (OBH) liaison for review of Medical Necessity Criteria.

2. Community Care or Allegheny County OBH will follow up with the referral source to review the referral and request additional information if needed.

3. If the individual being referred does not meet Medical Necessity Criteria, Community Care/OBH recommendations will be made for an alternative and appropriate level of support and treatment necessary to address the needs of the person being referred.

4. If the individual being referred meets Medical Necessity Criteria, Community Care will forward the referral form to the provider and confirm the date that the specialized services team plans to make initial contact with the individual. This date and the team assigned will be relayed by Community Care to the referral source.

5. Once the specialized services are approved and a provider is assigned, the referral source should obtain a signed Release of Information and fax the clinical records (including the most recent psychiatric evaluation and list of medications) directly to the assigned provider. Records should be faxed within 5 days of assignment.

Reminder: If approved for IDDT or ECSC, all current mental health treatment and service coordination will end and all services will be provided by IDDT or ECSC. Individuals will have up to 60 days to transition from current mental health services to IDDT or ECSC.

Service: (select one)

Must be 21 or older to receive this service:
◯ Enhanced Clinical Service Coordination

Must be 18 or older to receive this service:
◯ Integrated Dual Disorders Treatment

Member Information

Name: (First) _____ (Last) _____

MA ID #: | | | | | | | | | | | DOB: *(mm/dd/yyyy)*

Home Address: _____

Home Phone #'s: *(no dashes)* (main) _____ (other) _____

Guardian Name: _____ Guardian Phone #: *(no dashes)*

Guardian Address: _____

I certify that this specialized service has been explained to me and I am willing to accept these services at this time.

Signature of Person Referred _____ Date: *(mm/dd/yyyy)*

If no signature obtained, reason why:

Name of person who completed referral/ explained specialized services to person being referred: _____ Phone #: *(no dashes)*

Include information regarding the clinical rationale for requesting specialized services:

*****Attach the most recent psychiatric evaluation to this referral prior to sending it to Community Care .******

Diagnosis

Please include a primary behavioral health diagnosis. Other diagnoses may be included.

ECSC: Must have a primary diagnosis of a serious mental illness (Major Depressive Disorder, Bipolar Disorder, Psychosis NOS, Schizophrenia, or Schizoaffective Disorder)
IDDT: Must have a primary diagnosis of a serious mental illness (Major Depressive Disorder, Bipolar Disorder, Psychosis NOS, Schizophrenia, or Schizoaffective Disorder) or Post Traumatic Stress Disorder and one or more co-occurring substance use disorders.

Behavioral Health _____

Behavioral Health _____

Behavioral Health _____

Medical Conditions/
Physical Health Issues _____

Medical Conditions/
Physical Health Issues _____

Medical Conditions/
Physical Health Issues _____

List of all current medications and dose or attach a medication list (Do not attach an MAR):

_____

_____

_____

_____

Does the person need any assistive devices, supports, or accommodations in order to communicate with others? If so, please list them here:

_____

_____

_____

_____

Services

List Hospitalizations, Incarcerations, and Emergency Encounters in last 12 months (list most recent first):

	Type/Facility	Date *(mm/dd/yyyy)*
1.		
2.		
3.		
4.		

Treatment Services in past 5 years (IOP, Partial, CTT, etc). Please provide reason service was discontinued:

1. _____
2. _____
3. _____

Current Services:

Current	Provider/Agency	Contact Name	Contact Phone No. *(no dashes)*	Date of Initial Contact *(mm/dd/yyyy)*	Next Appointment *(mm/dd/yyyy)*
Outpatient Psychiatrist					
Service Coordinator					
Outpatient Therapist					
Primary Care Physician					
Peer Support/ Recovery Specialist					
Specialized Services					

List Substance Use/Dependence

	Type Used	Frequency	Date of last use *(mm/dd/yyyy)*
1.			
2.			
3.			
4.			

History of Life Threatening Suicide Attempts/Life Threatening Self Harm

	List Specific Behaviors/Method	Outcome (admitted to, etc.)	Date *(mm/dd/yyyy)*
1.			
2.			
3.			
4.			

Legal History

List current or history of legal charges. List if on probation or parole. Provide history of impulsive acting out, physical assault or uncontrolled anger that resulted in physical harm or real potential harm to others (ex. assault, rape, arson).

	List Impulsive/Acting Out Behavior	Outcome *(admitted to, etc.)*	Date *(mm/dd/yyyy)*
1.			
2.			
3.			

Assessment of Strengths

1. _____

2. _____

Support System

List current natural support system (family, friends, or social programs) and the frequency of contact. If there were natural supports who are no longer involved, provide a brief reason why no longer involved.

	List Supports/Relationships	Frequency of Contact/Last Contact	Reason No Contact
1.			
2.			
3.			

Psychotic or Mood Related Symptoms

Identify psychotic or mood related symptoms person experiences when symptomatic that interfere with daily functioning.

1. _____

2. _____

3. _____

Current Housing Placements and History

List most recent first.

1. _____

2. _____

3. _____

Is person homeless? If so please describe:

◯ Street homeless ◯ Living in a shelter ◯ At imminent risk of homelessness ◯ Fleeing domestic violence

Tobacco Cessation

Tobacco screen completed on: *(mm/dd/yyyy)* _____

Tobacco user? ◯ Yes ◯ No

Has cessation been discussed? ◯ Yes ◯ No

Is member interested in a referral for tobacco cessation?

◯ Yes ◯ No

☐ Referred to Tobacco Cessation Therapist/Program

☐ Referred to Quit Line

To be completed by Community Care/OBH

Accepted/Approved for Assignment ( ):

Specialized Service _____

Assigned Team _____

MCO Reviewer _____ Date *(mm/dd/yyyy)* _____

Allegheny County OBH Reviewer _____ Date *(mm/dd/yyyy)* _____