Allegheny County Department of Human Services
Service Coordination Referral Form **ADULT SERVICES**

REFERRAL DATE:	SERVICE PARTICIPANT NAME:

FORM INSTRUCTIONS

1. Only ONE service provider can be requested at a time.
2. Please be specific when describing the need for Service Coordination.
3. All sections of this document must be completed thoroughly and typed in order to make a determination of services.
4. Items should not be left blank-please indicate N/A where appropriate.
5. Incomplete referrals will not be accepted.
6. A current psychiatric evaluation (completed by MD) within past 12 months, and a list of the most recent medications must be attached with the referral.
7. The signature of the person being referred is required indicating that they understand that a referral is being made. ** If the person is unable to sign, the referral source must state if it is due to current symptoms, physical limitations, or other.
8. Email is preferred, unless delineated by specific provider.
9. Only fax if necessary or delineated by specific provider preference.

REFERRAL SOURCE RESPONSIBILITY

1. If Service Coordination Unit is unable to contact the referred individual, the referral source will be responsible for assisting the Service Coordination Unit in contacting the referred individual.
2. If an individual is being referred by a hospital, the referral should be submitted as soon as it is recognized that they are in need of Service Coordination.

NAME OF PROVIDER REFERRAL IS BEING MADE (**ONLY ONE** may be selected):

☐ Chartiers ☐ WFS ☐ Pgh Mercy ☐ Milestone ☐ MYCS ☐ Staunton ☐ TCV ☐ WPH

ADULT SERVICE COORDINATION PROVIDERS IN ALLEGHENY COUNTY

Chartiers Center
412-221-3302 (Ph)
412-257-2008 (**Fax- preferred**)
mturk@chartierscenter.org

Pittsburgh Mercy
412-323-8026 (Ph)
412-320-2376 (Fax)
SCREFERRALS@PittsburghMercy.org

Milestone Centers
412-243-3400 (Ph)
412-244-4781 (Fax)
Mcampbell@milestonepa.or

Wesley Family Services
724-230-2777 (Ph)
724-230-2778 (Fax)
Christina.Shaner@wfspa.org

ADULT SERVICE COORDINATION PROVIDERS IN ALLEGHENY COUNTY (cont'd)

Staunton Clinic
412-749-7330 (Ph)
412-749-7765 **(Fax- preferred**)
rkyle@hvhs.org

Mon- Yough Community Services (MYCS)
412-675-8480 (Ph)
412-664-0109 (Fax)
MYCSFAXADULTSC@UPMC.edu

Turtle Creek Valley (TCV)
412-351-0222 (Ph)
412-351-0695 (Fax)
twynn@tcv.net

Western Psychiatric Hospital (WPH)
412-204-9001 (Ph)
412-204-9134 (Fax)
BSCreferrals@upmc.edu

Section A. ELIGIBILITY CRITERIA

I. Persons eligible for Adult Service Coordination are 18 years of age or older, who have a Diagnosis within the DSM IV R (or succeeding revisions thereafter) completed by a Doctor, excluding those with a principal diagnosis of Intellectual Disability (formerly mental retardation), psychoactive substance use, organic brain syndrome or V-Code.

II. Treatment History: Must have one (1) of the following:

☐	Six or more days of inpatient treatment within the past twelve months
☐	Met standards for involuntary treatment within the past twelve months
☐	Two or more face to face contacts with emergency personnel within the past twelve months (i.e. after hours, Crisis Services, ER visits, Police)
☐	Missed at least three or more community mental health service appointments (within what time period), or documentation that the consumer has not maintained medication regimen for a period of at least 30 days.
☐	Transfer from another Service Coordination Provider Current Service Provider:
☐	Currently receiving or in need of MH services or in need of services from two or more human services agencies or public systems such as Drug and Alcohol, Vocational Rehabilitation, Criminal Justice, etc. Anticipated closure date:

III. Reason for referral: *Indicate **SPECIFIC REASON** how service Participant could benefit from Service Coordination, keeping in mind a need for transportation is NOT a reason for referral*

Section B. Referral Source Information

Referral Source:	☐CTT ☐Inpatient ☐JRS ☐ECSC ☐OP ☐Other		
Referral Source			
Agency Name:			
Phone#:		Cell #	Fax#
Email:			
Supervisor name:		Phone:	Email:

Section C. Service Participant Demographics

Name:	Last		First	
Alias Name:	Last		First	
Date of Birth:		Age	SS#	Gender
Ethnicity:		Primary Language:		
Marital Status:	☐Single ☐ Married ☐ Divorced ☐Separated ☐ Widow ☐ Partnered			
Veteran:	☐Yes ☐No	If yes, year of discharge?		Branch:
Permanent Address:	☐ *check here if Homeless*			Zip code
Homeless:	☐ YES ☐ NO	Identified contact Name: Phone Number:		
Current Address: (*if someplace other than permanent address)*	Facility Name:	Address:		Phone:
Contact Numbers	Home:	Cell:		Best time to call:
Email Address:				
Accommodations:	☐TTY ☐ Interpreter ☐ Sign language ☐ Ambulatory limitations ☐ Other			

Section D. Financial Information/Source of Income

Monthly Amount:		
Source of Income:	☐SSI ☐SSD ☐VA ☐Retirement ☐Child Support ☐Other:	
If source of income is pending, please describe and give date of application: SOAR Application: ☐ YES ☐ NO Date of application: Additional Information:		
Representative Payee Name: (if applicable)		Phone:
Power of Attorney: (if applicable)		Phone:

Section E. Health Insurance Information

Medical Assistance: ☐ Yes ☐ No	Medicare: ☐ Yes ☐ No	Other:
Medical Assistance or ID #:		

Section F. Emergency Contact Information

Name:	Relationship:
Address:	
Phone Number:	
Guardian Name if applicable:	Phone:

Section G. Health and Wellness

Known Allergies:
Does participant have a Mental Health Advanced Directive (MHAD) completed within 1 year: ☐Yes ☐No
Does participant have a Wellness Recovery Action Plan (WRAP) completed with 1 year: ☐Yes ☐No *** If participant has a MHAD or WRAP Plan, please attach

Section H. Other Agency/Program Involvement LIST ALL ACTIVE SERVICES:

Program Support: ***(choose from drop-down menu)***	Agency:	Name of primary provider contact:	Phone:	Email:
choose an item				
choose an item				

choose an item				
choose an item				
choose an item				

☐CHIPP ☐ACSP ☐CSP/CIT	If Applicable to CSP/ACSP please attach plan

Has the individual previously received SC Services? ☐ Yes ☐ No
If yes, previous provider:

Has a referral been made to any housing programs ☐Yes ☐No If yes, date referral was made:

Explanation/Type of Housing:

Section I. Mental Health Information *(DSM Diagnosis- Please attach a recent psychiatric evaluation or Doctor's signature to verify diagnosis completed within past 12 months).*

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

Behavioral Health:		Code:
Behavioral Health:		Code:
Medical Conditions:		
Medical Conditions:		
Last Psychiatric Eval:		Completed by:

Section J. Current Outpatient Provider/Services/Supports

CURRENT PROVIDER	PROVIDER AGENCY	CONTACT NAME	CONTACT PHONE NUMBER
Outpatient			
Outpatient Therapist:			
Primary Care			
Medical Specialist:			

Section K. Risk Factors *(Additional sheets can be attached if needed)*	Yes	No	Time Frame
Suicidal ideation/attempt? Explain:	☐	☐	
Self- injurious behaviors? Explain:	☐	☐	

Physical Harm to Others? Explain:	☐	☐	
Victimization of Others? Explain:	☐	☐	
Destruction of Property? Explain:	☐	☐	
Fire Setting? Explain:	☐	☐	
Sexually Inappropriate or Offensive Behaviors? Explain:	☐	☐	
Megan's Law Registry? Explain:	☐	☐	
Protection from Abuse (PFA)? Domestic Violence? Explain:	☐	☐	
Risk of Eviction or homelessness? Explain:	☐	☐	
Access to weapons in the home or elsewhere? Explain:	☐	☐	
Gang Involvement? Explain:	☐	☐	
Major Medical concerns? Explain:	☐	☐	
Pets in the home? Explain:	☐	☐	

Section L. Legal History *(attach additional sheets if needed)*

CRIMINAL CHARGES CURRENT/ PAST 5 YEARS ***(choose from drop-down menu)***	**ARREST DATE** **(IF APPLICABLE)**	**OUTCOME OF ARREST (IF APPLICABLE)**	**RELEASE DATE** **(IF APPLICABLE)**	**CONVICTED**	**CONVICTION/ DISPOSITION (IF APPLICABLE)** ***(choose from drop-down menu)***
other (please specify)		not jailed		☐ **YES** ☐ **NO**	choose an ite
other (please specify)		not jailed		☐ **YES** ☐ **NO**	choose an ite
other (please specify)		not jailed		☐ **YES** ☐ **NO**	choose an ite
other (please specify)		not jailed		☐ **YES** ☐ **NO**	choose an ite
other (please specify)		not jailed		☐ **YES** ☐ **NO**	choose an ite

other (please specify)		not jailed		☐ YES ☐ NO	choose an ite

If OTHER Charge Identified Explain:

Probation or Parole Involved? ☐ **YES** ☐ **NO** **If Yes, Level:** ☐ **County** ☐ **State** ☐ **Federal**

P.O. Name: Phone: Email:

Section M. AUTHORIZATION FORM

I agree to this referral and authorization. In an event I cannot be reached, or additional information is needed, I authorize other service providers or organizations listed on this referral be contacted on my behalf for the purpose of coordinating this referral.

Print Name _____ Date _____

Service Participant Signature _____

Print Name _____ Date _____

Guardian Signature _____

Print Name _____ Date _____

Referral Source Signature _____

Is Service Participant agreeable to services? ☐ Yes ☐ No
If No, explain: