



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 or psychological 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, or Guardian 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 or Guardian.
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. This will permit the SC to meet with the service participant before they are discharged from the inpatient unit.

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

ACI Chartiers HSAO MYCS Pgh Mercy Pressley Ridge Staunton TCV WFS WPH

ALLEGHENY COUNTY CHILD/ADOLESCENT SERVICE COORDINATION PROVIDERS

Allegheny Children’s Initiative (ACI)

412-431-8006 (Ph)
412-431-8124 (Fax)
ACI-Intake@pfq.org

Chartiers Center

412-221-3302 x 221 (Ph)
412-257-2008 (Fax- preferred)
JRosenberger@chartierscenter.org

Human Services Administration Organization (HSAO)

412-884-4500 (Ph)
412-885-3900 (Fax)
ahood@hsao.org

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

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

Pressley Ridge
 412-442-2080 (Ph)
 412-321-0508 (Fax)
Elisha C Hubbard
ehubbard@pressleyridge.org
 Charice Ely
cely@pressleyridge.org

Staunton Clinic
 412-749-7330 (Ph)
 412-749-7765 (Fax- preferred)
 Rachel Kyle rhyle@hvhs.org
 Lori Grubbs lgrubbs@hvhs.org

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

Wesley Family Services (WFS)
 724-895-8262 (Ph)
 724-230-2778 (Fax)
 Kimberly Romito
Kimberly.Romito@wfspa.org

Western Psychiatric Hospital (WPH)
 412-204-9001 (Ph)
 *Does not accept fax referrals
BScreferrals@upmc.edu

Section A. ELIGIBILITY CRITERIA

I. Persons eligible for Child/Adolescent Service Coordination are up to the age of 18 years (or to 21 if the Child/Adolescent has an Individualized Education Plan (IEP) or is transitioning to the adult system) who has 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:

<input type="checkbox"/>	At risk for out-of-home placement without services.
<input type="checkbox"/>	Returning from community inpatient or other out of home placement.
<input type="checkbox"/>	Age 6 years or younger and require or enrolled in Early Intervention Services.
<input type="checkbox"/>	Receiving with their family, services from 2 or more publicly funded programs.
<input type="checkbox"/>	Transfer from another Service Coordination Provider Current Service Provider:
<input type="checkbox"/>	Recommended as needing MH Services by local county interagency team.
<input type="checkbox"/>	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, CYF, Juvenile Probation, 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

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Section B. Referral Source Information

Referral Source Name:		Title:	
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: Choose One
Ethnicity:	Primary Language:		
Grade in School:	Name of School:		
Special Education:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Level:	
Permanent Address:	<input type="checkbox"/> check here if Homeless	Address:	Zip code
If checked Homeless above:	Identified contact Name:	Phone Number:	
		Address:	
Current Address: <i>(if someplace other than permanent address)</i>	Facility Name:	Address:	Phone:
Contact Numbers	Home:	Cell:	Best time to call:
Email Address:			
Accommodations:	<input type="checkbox"/> TTY <input type="checkbox"/> Interpreter <input type="checkbox"/> Sign language <input type="checkbox"/> Ambulatory limitations <input type="checkbox"/> Other		

Parent:	Last Name:	First Name:
Parent Phone:	Home:	Cell:
Parent Email:		
Guardian Name:		Provider Affiliation: (If applicable)
Guardian Type:	<input type="checkbox"/> Medical/Educational Guardian <input type="checkbox"/> Guardian ad litem <input type="checkbox"/> Permanent legal custodian	
Guardian Phone:	Home:	Cell:
Guardian Email:		

Section D. Financial Information/Source of Income

Monthly Amount:		
Source of Income:	<input type="checkbox"/> SSI <input type="checkbox"/> SSD <input type="checkbox"/> Child Support (if applicable) <input type="checkbox"/> Other:	
If source of income is pending, please describe and give date of application: SOAR Application: <input type="checkbox"/> YES <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No	Other:
Medical Assistance or ID #:		

Section G. Health and Wellness

Known Allergies:
For 18 and Older: Does participant have a Mental Health Advanced Directive (MHAD) completed within 1 year: <input type="checkbox"/> Yes <input type="checkbox"/> No
For 18 and Older: Does participant have a Wellness Recovery Action Plan (WRAP) completed with 1 year: <input type="checkbox"/> Yes <input type="checkbox"/> No
*** If participant has a MHAD or WRAP Plan, please attach***

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

Program Support: <i>(choose from drop-down menu)</i>	Agency:	Name of primary provider contact:	Phone:	Email:
Choose an item.				
Choose an item.				
Choose an item.				
Choose an item.				
Choose an item.				
<input type="checkbox"/> ACSP <input type="checkbox"/> CIT		If Applicable to CSP/ACSP please attach plan		
Has the individual previously received SC Services? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, previous provider:				
Has a referral been made to any housing programs <input type="checkbox"/> Yes <input type="checkbox"/> 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 Psychiatrist:			
Outpatient Therapist:			
Primary Care Physician:			
Medical Specialist:			
IBHS (BHRS):			
Family Based/Family Focused:			
Residential Treatment Facility:			

Section K. Risk Factors <i>(Additional sheets can be attached if needed)</i>	Yes	No	Time Frame
Suicidal ideation/attempt? Explain:	<input type="checkbox"/>	<input type="checkbox"/>	
Self- injurious behaviors? Explain:	<input type="checkbox"/>	<input type="checkbox"/>	
Physical Harm to Others? Explain:	<input type="checkbox"/>	<input type="checkbox"/>	
Victimization of Others? Explain:	<input type="checkbox"/>	<input type="checkbox"/>	
Destruction of Property? Explain:	<input type="checkbox"/>	<input type="checkbox"/>	
Fire Setting? Explain:	<input type="checkbox"/>	<input type="checkbox"/>	
Sexually Inappropriate or Offensive Behaviors? Explain:	<input type="checkbox"/>	<input type="checkbox"/>	
Megan’s Law Registry? Explain:	<input type="checkbox"/>	<input type="checkbox"/>	
Probation: Explain:	<input type="checkbox"/>	<input type="checkbox"/>	
Protection from Abuse (PFA)? Domestic Violence? Explain:	<input type="checkbox"/>	<input type="checkbox"/>	
Risk of Eviction or homelessness? Explain:	<input type="checkbox"/>	<input type="checkbox"/>	
Access to weapons in the home or elsewhere? Explain:	<input type="checkbox"/>	<input type="checkbox"/>	
Gang Involvement? Explain:	<input type="checkbox"/>	<input type="checkbox"/>	
Major Medical concerns? Explain:	<input type="checkbox"/>	<input type="checkbox"/>	

Pets in the home? Explain:	<input type="checkbox"/>	<input type="checkbox"/>	
School Problems?	<input type="checkbox"/>	<input type="checkbox"/>	
Family Concerns?	<input type="checkbox"/>	<input type="checkbox"/>	
Other?	<input type="checkbox"/>	<input type="checkbox"/>	

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

CRIMINAL CHARGES CURRENT/ PAST 5 YEARS <i>(choose from drop-down menu)</i>	ARREST DATE <i>(IF APPLICABLE)</i>	OUTCOME OF ARREST <i>(IF APPLICABLE)</i>	RELEASE DATE <i>(IF APPLICABLE)</i>	CONVICTED	CONVICTION/ DISPOSITION <i>(IF APPLICABLE)</i> <i>(choose from drop-down menu)</i>
Choose an item.		Choose an item.		<input type="checkbox"/> YES <input type="checkbox"/> NO	Choose an item.
Choose an item.		Choose an item.		<input type="checkbox"/> YES <input type="checkbox"/> NO	Choose an item.
Choose an item.		Choose an item.		<input type="checkbox"/> YES <input type="checkbox"/> NO	Choose an item.
Choose an item.		Choose an item.		<input type="checkbox"/> YES <input type="checkbox"/> NO	Choose an item.
Choose an item.		Choose an item.		<input type="checkbox"/> YES <input type="checkbox"/> NO	Choose an item.
Choose an item.		Choose an item.		<input type="checkbox"/> YES <input type="checkbox"/> NO	Choose an item.

If OTHER Charge Identified Explain:

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 _____
(14 or older):

Print Name _____ Date _____

Guardian Signature _____

Print Name _____ Date _____

Referral Source Signature _____

Is Service Participant agreeable to services? Yes No

If No, explain: