



Justice Related Services

Referral Form

For questions about the referral process or Justice Related Services, please call 610-500-2111.

Eligibility: To qualify for forensic blended case management services, individual must be 18 or over with a Severe Mental Illness diagnosis and have law enforcement involvement. Psychiatric evaluation must be attached to confirm eligibility.

Date of Referral:	SSN:	Preferred Method of Contact:
Phone Number:	Texting Number:	Email:
Applicant's Name:		DOB:
		Gender:
		Race/Ethnicity:
		Language Spoken:
Address (if homeless, last known address):		
Referred by:		Title:
Agency:		Phone:
		Email:
Reason for Referral:		
List all Diagnosis with V-Code:		
Treatment History: Check all that apply		
	Met standards for involuntary inpatient treatment within past 12 months	
	6 or more days of psychiatric treatment in the past 12 months	
	2 or more face-to-face encounters with crisis or emergency services within the past 12 months	
	At least 3 missed Community Mental Health appointments within the past 12 months	
	Documentation that the consumer has not maintained his/her medication regimen for a period of at least 30 days	
	Currently receiving or in need of MH services from 2 or more Human Service agencies/public systems such as D/A, OVR, Criminal Justice, etc.	
	Adults who received any type of CM services as children and were recommended by the provider and approved by the County Administrator or the Behavioral Health Managed Care Organization as needed BCM services beyond the date of transition from child to adult.	

Forensic Status: Check all that apply

- Incarcerated – Location/Expected release date: _____
- Not Sentenced- Date of next court hearing: _____
- Probation/Parole Behavioral Health Court
- Coordinate expedited release or discharge from incarceration or hospitalization.
- Frequent police contact in the community

Housing Status:

- Homeless – sleeping in shelters, places not meant for human habitation, e.g. cars, streets, abandoned buildings
- At risk of homelessness – house has been condemned, received eviction notice, can't afford bills, etc.
- Unstable housing plan, explain:

Current Services and Supports:

- Outpatient Provider:
- Psychiatrist Name:
- ACT / RC / CM Provider:
- Other Services and Supports:

Insurance (check all that apply)		Income Source (Check all that apply)		Monthly Amount
<input type="checkbox"/> Magellan	<input type="checkbox"/> County funding	<input type="checkbox"/> Employment	<input type="checkbox"/> SSI/SSDI	
<input type="checkbox"/> Medicare	<input type="checkbox"/> Private	<input type="checkbox"/> Cash Assistance		
<input type="checkbox"/> Uninsured		<input type="checkbox"/> Other		

Additional Information:

Has the applicant consented to this referral: Yes No

Signature of Referral Source: _____ Date: _____

*Name of Psychiatrist: _____

*Signature of Psychiatrist: _____ Date: _____

*Name & Signature of psychiatrist must be present if no psychiatric evaluation is attached.