



# Justice Related Services Referral Form

Please send referral and most recent psychiatric and medical evaluations to: [jrsleadership@accessservices.org](mailto:jrsleadership@accessservices.org)

\*If you do not have a recent psych/medical eval we will help you obtain one. For questions, please call: 610.500.2111 ext. 1.

Date of Referral: \_\_\_\_\_

**Note:** To work with JRS the individual MUST have Legal System Involvement and a Serious Mental Health Diagnosis

## Individual's Information

\*Name: \_\_\_\_\_ \*Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

\*Social Security Number: \_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_

Is this individual *Hispanic*:  Yes  No  Unknown      Is the Individual a Veteran:  Yes  No  Unknown

Language Spoken (other than English): \_\_\_\_\_ Marital Status: \_\_\_\_\_

Address (if homeless or currently looking for residential, last known address or where the individual frequents):

\*Phone: \_\_\_\_\_ Cell (Texting Number): \_\_\_\_\_

Preferred Method of Contact: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact (if individual doesn't have contact information): \_\_\_\_\_

Do you have the following? (If you do not have any of the following, leave unchecked)

Social Security Card  Birth Certificate  State ID, which state? \_\_\_\_\_

Driver's License, which state? \_\_\_\_\_ (check one)  Valid  Suspended  Expired

## Referral Source Information

Name of Referral Source: \_\_\_\_\_ Organization: \_\_\_\_\_

Nature of Relationship to Person Referred: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Reason for Referral** (Check all that apply):

Re-Entry planning from jail  Frequent Police Contact  In need of Mental Health Services  Probation

Housing Support  Other, please specify:

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**Benefit and Financial Information**

Income:

Employment  SSI  SSDI  Cash Assistance  SNAP  Other, please specify: \_\_\_\_\_

*Source*

*Amount*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Rep Payee: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance:

Magellan  County Funding  Medicare  Private, what company? \_\_\_\_\_

Uninsured

Are there pending applications for benefits or insurance? If so, what are they and who helped you with this?

\_\_\_\_\_  
\_\_\_\_\_

**Housing Status**

Homeless – *sleeping in shelters, places not meant for human habitation (cars, streets, abandoned buildings)*

At risk of homelessness – *house has been condemned, received eviction notice, can't afford bills, etc.*

Unstable housing, explain: \_\_\_\_\_

Pending residential application, which and where? \_\_\_\_\_

Contact information for pending residential application: \_\_\_\_\_

**\* Forensic Status** (Check all that apply):

Incarcerated – Location/Expected release date: \_\_\_\_\_

Not Sentenced – Date of next court hearing: \_\_\_\_\_

Probation/Parole  Behavioral Health Court  Drug Court  Frequent police contact in the community

Coordinate expedited release or discharge from incarceration or hospitalization.

Explain: \_\_\_\_\_

\_\_\_\_\_

If on **Probation**, please provide the Probation Officers Contact Information:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_

**\* 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 regime for a period of at least 30 days.
- Currently receiving or in need of Mental Health services from 2 or more Human Services agencies/public systems such as D/A, OVR, Criminal Justice, etc.
- Adults who received any type of Case Management Services as children and were recommended by the provider and approved by the County Administrator or the Behavioral Health Managed Care Organization as needed Blended Case Management services beyond the date of transition from child to adult.

**List all Mental Health Diagnosis with V-Code** (such as Major Depression, Bipolar, Borderline Personality, Schizophrenia, Schizoaffective, Psychosis, and Post-Traumatic Stress Disorders):

**Current Services and Supports Information**

**Emergency Contact:**

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_  
Email: \_\_\_\_\_

**Natural Support/Relative** *(if not listed as emergency contact)*

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_  
Email: \_\_\_\_\_

**Substitute Decision Maker** *(someone who can make medical decisions for the individual in the event they are unable to):*

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_  
Email: \_\_\_\_\_

**Recovery Coach/Blended Case Manager:**

*\*For Montgomery County these services cannot overlap for more than 30 days.*

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_  
Email: \_\_\_\_\_

**Therapist/Counselor:**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

**Psychiatrist:**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

**Heath Information**

Date of Last Physical: \_\_\_\_\_

Physical Health diagnosis/concerns: \_\_\_\_\_  
\_\_\_\_\_

Current medications, dosages, and frequencies (or attached medication list): \_\_\_\_\_  
\_\_\_\_\_

Allergies: \_\_\_\_\_

**Primary Care Physician:**

Practitioner's Name: \_\_\_\_\_

Name & Address of Practice: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

**Specialist:**

Practitioner's Name: \_\_\_\_\_

Name & Address of Practice: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

**Additional Client Information:**

Highest Education Level Completed: \_\_\_\_\_

Is there a traumatic history that you want us to be aware of?  
\_\_\_\_\_

Has *substance abuse* been a struggle? Primary substance and date of last use?  
\_\_\_\_\_

Current or history of struggling with *thoughts of suicide*?  
\_\_\_\_\_

Current or history of having thoughts or acted on *violent impulses*?  
\_\_\_\_\_

**How can blended case management be helpful?**

Goals and hopes for our support:

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Helpful approaches to support:

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Unhelpful approaches to support:

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**Additional Comments or thoughts:**

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Has the applicant consented to the 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.*