Justice Related Services Referral Form

Please send referral and most recent psychiatric and medical evaluations to: 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:

_____

_____

_____

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)**:**

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:

_____

_____

Helpful approaches to support:

_____

_____

Unhelpful approaches to support:

_____

_____

Additional Comments or thoughts:

_____

_____

_____

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.*