LEHIGH/NORTHAMPTON COUNTIES CASE MANAGEMENT AND/OR CERTIFIED PEER SPECIALIST REFERRAL APPLICATION FORM – CHILD/YOUTH

Section I: Demographic Information. ***To be completed by the individual if 14+***

Date of Referral:	Child/Youth's Name:		DOB & Age:
SSN:	Preferred Language:	Gender Identity:	Assigned Sex at Birth:
Address (if homeless, last known address):			
Primary Contact's Phone:	Ok to leave a voice mail? ☐ Yes ☐ No		Primacy Contact's Email:
Currently enrolled in school: ☐ Yes ☐ No	School:		
Grade: _____ IEP: ☐ Yes ☐ No	School Contact:		
Parent/Guardian/Emergency Contact:	Phone:		Email:
Address: ☐ Same as above			

Providers: Please check the provider you are sending this referral to. Please pick only one provider.

☐ **Pennsylvania Mentor**
☐ ICM ☐ RC (check one)
Fax: 610-867-2695 **Phone**: 610-867-3173

☐ **RHA Health Services**: BCM
Fax: 610-391-1682 **Phone**: 610-973-0971

☐ **Access TIP** (Transition to Independence): ICM
Email: TIP@accessservices.org
Phone: 215-317-9939

☐ **Chimes Holcomb Behavioral Health:** ICM *(Spanish Speaking)* Referral Contact: Emily Shosh
- Easton: **Fax**: 610-330-2853 **Phone**: 610-330-9862
- Allentown: **Fax**: 610-435-3044 **Phone**: 610-435-4151

☐ **Nulton Diagnostic & Treatment Center**: BCM
Fax: 610-391-1682 **Phone**: 610-224-9311

☐ **Valley Youth House**: CPS (Ages 14-26)
Fax and Phone: 610-820-0166

Section II: ***To be completed by Referral Source*****:**

Referred by:		**Title/Position:**	
Agency:		**Phone/Email:**	

Reason for Referral (How would this person benefit from Case Management or a Certified Peer Specialist):

☐ Housing/living situation
Please specify:
- ☐ Living with relatives or friends.
- ☐ Non-housing (street, park, car, etc.)
- ☐ Emergency Shelter
- ☐ Other (Please specify): _____

☐ Activities of daily living (Bathing, dressing, etc.)
☐ Childcare
☐ Criminal Justice
☐ Drug and alcohol treatment
☐ Education/Vocational training & supports
☐ Finding, getting, or keeping a job
☐ Food
☐ Getting or maintaining benefits
☐ Help with medical bills
☐ Legal issues (not criminal)
☐ Managing money or budget help
☐ Mental Health treatment provider
☐ Primary Care Physician/provider
☐ Safety
☐ Social activities
☐ Social Security Benefits
☐ System Navigation
☐ Transportation advice or options
☐ Understanding my health needs
☐ Utilities
☐ Other: _____

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Section III: Risk Assessment

Is the child/youth at CURRENT risk or do they have a history of:

Risk/Behavior	Current Risk		Describe	History		Describe
	Yes	No		Yes	No	
Trauma	☐	☐		☐	☐	
Suicidality	☐	☐		☐	☐	
Homicidal	☐	☐		☐	☐	
Violence	☐	☐		☐	☐	
Fire setting	☐	☐		☐	☐	
Property destruction	☐	☐		☐	☐	
Aggressive/Assaultive Behaviors	☐	☐		☐	☐	

Is the child/youth able to contract for safety?	☐ Yes ☐ No
Is the child/youth compliant with their medication regime?	☐ Yes ☐ No ☐ N/A
Are there any weapons in the home?	☐ Yes ☐ No
Does the child/youth have legal charges pending?	☐ Yes ☐ No
Is the child/youth currently using drugs and/or alcohol?	☐ Yes ☐ No
If yes, please describe:	

Section IV: Eligibility Criteria for BCM/ICM/RC and CPS Services:

Diagnosis – The individual being referred must have a diagnosis within DSM V excluding those with a principal diagnosis of intellectual disability, psychoactive substance abuse, organic brain syndrome or a V-Code.

Mental Health DSM V Diagnoses (with codes):	**Physical Health Diagnoses:**

Section V: Attachments

Please select AND attach the following:

☐ Proof of Diagnosis:
- ☐ Psychiatric evaluation within the past 6 months **OR**
- ☐ Recent treatment notes and documentation of Mental Health diagnoses. Child/Youth will need assistance scheduling a psychiatric evaluation.

☐ Complete list of current medications

Please Note: If referral is for Certified Peer Specialist; a recommendation must be signed below by a Practitioner of the Healing Arts, consisting of either a physician, licensed psychologist, certified registered nurse practitioner, or physician's assistant. The Individual being referred to CPS services must also sign below.

Signature AND credentials of Licensed Practitioner of the Healing Arts	**Date**
Printed Name:	**Phone:**
Address:	

Individual's Signature if 14+	**Date**