TARGETED CASE MANAGEMENT PROGRAM REFERRAL

Please complete each section of this application. Please write not applicable (N/A) or unknown if a question does not apply or if the referral source does not know the information.

SECTION A: RELEASE/CONSENT FORM

Date: _____ Name: _____ DOB: _____

SS #: _____ Phone #: _____

Address: _____

Being referred to receive Targeted Case Management services in the following county:

Wicomico ☐	Worcester ☐	Somerset ☐
Wicomico Co Health Dept 108 E. Main St. Salisbury MD 21801 Ph-410-548-5179 **Fax 410-543-6680**	Wraparound Maryland, Inc. 1118 East Main Street Salisbury, MD 21804 Ph-410-219-5070 **Fax 410-219-5072**	Wraparound Maryland, Inc. 1118 East Main Street Salisbury, MD 21804 Ph-410-219-5070 **Fax 410-219-5072**

Referring Agency: _____

Agency Contact Person: _____ Phone#: _____

Fax #: _____ Email: _____

Please review and sign for Consent to Services *and* Information Release.

Consent to Services:

I understand that I am applying for case management services for the Targeted Case Management Program in the county indicated above. I agree to receive these services if approved and to participate in the development of a Service Plan, which I will be asked to sign. I understand that I may revoke my consent to services at any time by written or verbal request.

Consumer Signature (or Guardian): _____ Date: _____

Witness: _____ Date: _____

Information Release:

I authorize the above referenced referring provider to furnish to the agency representing the county indicated above the information requested on the Targeted Case Management Program Referral for review. This information will used to make a pre-determination of eligibility for case management services. If found eligible for services, I further authorize the release of information to the Targeted Case Management program for full screening and service eligibility determination and to the Administrative Services Organization (ASO) to determine eligibility for Targeted Case Management services. I understand that I may revoke my permission at any time by written or verbal request.

Consumer Signature (or Guardian) _____ Date: _____

Witness: _____ Date: _____

SECTION B: DEMOGRAPHICS AND REQUIRED REPORTING DATA

1. Please complete the following for *ALL* consumers

Race
- ☐ White
- ☐ American Indian or Alaskan Native
- ☐ Black or African American
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander

Gender
- ☐ Male
- ☐ Female
- ☐ Transgender – Male to Female
- ☐ Transgender – Female to Male
- ☐ Other – please specify

Ethnicity
- ☐ Not Hispanic/Latino
- ☐ Hispanic/Latino

Marital Status
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widow/Widower

Sexual Orientation (OPTIONAL)
- ☐ Bisexual
- ☐ Lesbian/Gay
- ☐ Heterosexual/Straight
- ☐ Not Sure
- ☐ Other – feel free to explain

Employment Status
- ☐ Competitive Employment Full or Part Time
- ☐ Supported Employment Full or Part Time
- ☐ Unemployed – Looking for Work
- ☐ Retired
- ☐ Sheltered Employment
- ☐ Homemaker
- ☐ Student
- ☐ Disabled – Not in Workforce
- ☐ Not Seeking to Work
- ☐ Sheltered Workshop
- ☐ Volunteer

Living Situation
- ☐ Private Residence
- ☐ Foster Home
- ☐ Residential Care
- ☐ Crisis Residential
- ☐ Children 's Residential Treatment
- ☐ Institutional Setting
- ☐ Jail/Correctional Facility
- ☐ Homeless Shelter
- ☐ Other

Hurricane Victim
- ☐ Yes
- ☐ No

Served in the Military
- ☐ Yes
- ☐ No

SECTION C: INSURANCE AND FINANCIAL INFORMATION

1. Please indicate the consumer's current insurance coverage.

- ☐ Medical Assistance (please provide MA number) _____
- ☐ Medicare*
- ☐ Private Insurance-***Will not be eligible for Mental Health Case Management but may be eligible for other assistance**
- ☐ No Insurance Coverage*

*Uninsured individuals and individuals with only Medicare or QMB/SLMB coverage can only be approved for General Level **and must**: be discharged from a psychiatric hospital or jail, be diverted from a psychiatric hospital or jail, be at risk of homelessness or is homeless, and/or has been found NCR and TCM is part of the Conditional Release.

*****Please provide a copy of SS card and Proof of Income for Uninsured Individual***

2. Please provide the consumer's current income information.

	Monthly Income:

Annual Income:	
Income Source(s):	# of Dependents:

SECTION D: LEGAL INFORMATION

1. **Has the consumer been arrested in the last 30 days?** Yes ☐ No ☐

List any convictions, pending charges, or court dates. _____

SECTION E: AGENCY INVOLVEMENT

1. **Please list and describe any multi-agency involvement, such as DSS, PCP, Homeless Services, Supports, etc.**

SECTION F: CLINICAL INFORMATION

1. **Please provide the current DSM-5 diagnosis**

DSM-5 CODE	DISORDER

Does Consumer have a Co-Occurring alcohol or drug disorder? If yes, provide Dx.

Which social elements impact diagnosis? (check all that apply)

□ None □ Problems w/ Access to Healthcare Services □Housing Problems (Not Homeless) □Educational Problems

□ Problems Related to Social Environment □Legal System/Crime □Occupational Problems □Homelessness

□Financial Problems □Problems w/Primary Support Group □Unknown

□Other Psychosocial and Environmental Problems - Explain:

What are the consumer's primary medical diagnoses?

2. **Complete the following Risk Assessment.**

	Yes	No	***Please provide specific details of each item including dates***
Suicide Attempts/Ideations:			

History of Clinical Deterioration:			
Aggressive Behavior/ Violence:			

3. Please list any current or previous mental health and/or addiction treatment such as Outpatient Services, PRP, Case Management, ACT, Inpatient, Methadone etc..

*****If an individual is currently enrolled in a Psychiatric Rehabilitation Program (PRP) they are not eligible for enrollment in Targeted Case Management services***

_____

_____

_____

4. Medical Necessity Criteria (MNC): All applicants must meet the Medical Necessity Criteria to receive Targeted Case Management Services. Please complete the following clinical criteria chart to determine eligibility and level of case management services.

Eligibility Criteria for Adult Targeted Case Management Services:

Please write and/or type your response in the right hand column which justifies the specific eligibility criteria. If not completed, this referral may be returned to you requesting additional details.

a. **Adults** age 18 and over, who have a serious and persistent mental health disorder and who:	
i. Are at risk of, in need of continued community treatment to prevent, or are being discharged from inpatient psychiatric treatment *Please provide additional information that is not included in SECTION F, ITEM 5.*	☐ Yes ☐ No If answered **YES**, **please provide an explanation**:
ii. Are at risk of, or need continued community treatment to prevent being homeless *If yes, please explain current housing situation.*	☐ Yes ☐ No If answered **YES, please provide an explanation**:
iii. Are at risk of incarceration or will be released from a detention center of prison *Please provide additional information that is not included in SECTION D: LEGAL INFORMATION.*	☐ Yes ☐ No If answered **YES, please provide an explanation**:

b. **Adults: Levels of Case Management Service** Consumer will be assessed to determine whether appropriate for General Level (a minimum of 2 services per month) or for Intensive Level (a minimum of 5 services per month)	
i. Is consumer linked to mental health and medical services?	☐ Yes ☐ No If answered **NO**, **please provide additional information**:

If no, please provide additional treatment information that is not included in SECTION F, ITEM 5.	
ii. Does consumer lack basic supports for shelter, food and income? *If yes, please explain situation.*	☐ Yes ☐ No If answered **YES, please provide an explanation**:
iii. Is the consumer transitioning from one level of care to another level of care? *If yes, please explain situation (e.g. transitioning from incarceration to community, RTC/inpatient psychiatric admission to outpatient services, etc.)*	☐ Yes ☐ No If answered **YES, please provide an explanation:**
iv. Does the consumer need to maintain community-based treatment and services? *If yes, provide justification and explain what is anticipated if not engaged in treatment.*	☐ Yes ☐ No If answered**YES**, **please provide an explanation**:

SECTION G: RECOMMENDATIONS

1. **Case Manager Safety:**

☐ Check here if it is recommended that consumer be seen at the clinic instead of home. Case management consumers are usually seen in their homes; however, if the case manager's safety is at risk, the consumer will be seen outside the home.

If selected explain: _____

_____

2. **What service and/or benefits does the consumer need the Targeted Case Management Program to assist with? List the identified needs in priority order.**

_____

_____

_____

3. **Please provide any other information that would be helpful for the case manager.**

_____

_____

Public Health
Prevent. Promote. Protect.
Somerset County
Health Department

Somerset County Health Department

8928 Sign Post Road, Suite 2, Westover, Maryland 21871
443.523.1700 · Fax 410.651.5680 · TDD 1-800-735-2258

Health Officer Danielle Weber, MS, RN

Authorization for the Release of Confidential Information

Client Name: _____ DOB: _____ Patient ID# _____

Street Address: _____ Phone Number: _____

City, State, Zip: _____

I hereby authorize the Somerset County Health Department to: X Obtain X Release information to / from:

_____

The following information from my records (specify extent or nature of the information to be obtained or released):

_____

_____

The purpose of this authorized disclosure: _____

_____

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Pts. 160 and 164. These regulations prohibit you from making further disclosure of it without the specific written consent to whom it pertains or as otherwise specified by regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules may restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

Conditions for Exchange of Authorized Information
Expiration: This authorization will expire one year from the date signed unless specified below by date or event less than one year:

Date: _____/_____/_____ Event or Condition: _____

RIGHT TO REVOKE: I understand that I may revoke this authorization at any time by giving written notice, but not retroactive to release of information already made in good faith. USE SPACE BELOW ONLY IF CLIENT WITHDRAWS CONSENT.

Date Authorization Revoked by Client: _____/_____/_____ Signature of Client: _____

REDISCLOSURE: Any individual or agency receiving Somerset County Health Department client information is prohibited from making further disclosure of the medical record. This is prohibited as provided by the Annotated Code of Maryland 4-303(b)(5)(ii).

PHOTOSTAT/FACSIMILE: A photostat or facsimile of this authorization is considered as effective and valid as the original.

Date: _____ Signature of Client: _____

Date: _____ Signature of Parent or Guardian: _____

Date: _____ Witness to Signature: _____