

# 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 <input type="checkbox"/>	Worcester <input type="checkbox"/>	Somerset <input type="checkbox"/>
Wicomico Co Health Dept 108 E. Main St. Salisbury MD 21801 Ph-410-548-5179 Fax 410-543-6680	Worcester Co Health Dept 424 W Market St Suite A Snow Hill MD 21863 Ph-410-632-9230 Fax 410-632-9239	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 be 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: \_\_\_\_\_

# TARGETED CASE MANAGEMENT PROGRAM REFERRAL

## SECTION B: DEMOGRAPHICS AND REQUIRED REPORTING DATA

1. Please complete the following for ALL consumers

<p><b>Race</b></p> <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<p><b>Employment Status</b></p> <input type="checkbox"/> Competitive Employment Full or Part Time <input type="checkbox"/> Supported Employment Full or Part Time <input type="checkbox"/> Unemployed – Looking for Work <input type="checkbox"/> Retired <input type="checkbox"/> Sheltered Employment <input type="checkbox"/> Homemaker <input type="checkbox"/> Student <input type="checkbox"/> Disabled – Not in Workforce <input type="checkbox"/> Not Seeking to Work <input type="checkbox"/> Sheltered Workshop <input type="checkbox"/> Volunteer
<p><b>Gender</b></p> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender – Male to Female <input type="checkbox"/> Transgender – Female to Male <input type="checkbox"/> Other – please specify	<p><b>Living Situation</b></p> <input type="checkbox"/> Private Residence <input type="checkbox"/> Foster Home <input type="checkbox"/> Residential Care <input type="checkbox"/> Crisis Residential <input type="checkbox"/> Children 's Residential Treatment <input type="checkbox"/> Institutional Setting <input type="checkbox"/> Jail/Correctional Facility <input type="checkbox"/> Homeless Shelter <input type="checkbox"/> Other
<p><b>Ethnicity</b></p> <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino	
<p><b>Marital Status</b></p> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widow/Widower	<p><b>Hurricane Victim</b></p> <input type="checkbox"/> Yes <input type="checkbox"/> No
<p><b>Sexual Orientation (OPTIONAL)</b></p> <input type="checkbox"/> Bisexual <input type="checkbox"/> Lesbian/Gay <input type="checkbox"/> Heterosexual/Straight <input type="checkbox"/> Not Sure <input type="checkbox"/> Other – feel free to explain	
	<p><b>Served in the Military</b></p> <input type="checkbox"/> Yes <input type="checkbox"/> No

## SECTION C: INSURANCE AND FINANCIAL INFORMATION

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

<input type="checkbox"/> Medical Assistance (please provide MA number) _____ <input type="checkbox"/> Medicare* <input type="checkbox"/> Private Insurance- <b>*Will not be eligible for Mental Health Case Management but may be eligible for other assistance</b> <input type="checkbox"/> No Insurance Coverage*
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\*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:
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# TARGETED CASE MANAGEMENT PROGRAM REFERRAL

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	<i>Please provide specific details of each item including dates</i>
Suicide Attempts/Ideations:			

# TARGETED CASE MANAGEMENT PROGRAM REFERRAL

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.**

<b>a. Adults</b> 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 <i>Please provide additional information that is not included in SECTION F, ITEM 5.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No   If answered <b><u>YES</u></b> , please provide an explanation:
ii. Are at risk of, or need continued community treatment to prevent being homeless <i>If yes, please explain current housing situation.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No   If answered <b><u>YES</u></b> , please provide an explanation:
iii. Are at risk of incarceration or will be released from a detention center of prison <i>Please provide additional information that is not included in SECTION D: LEGAL INFORMATION.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No   If answered <b><u>YES</u></b> , please provide an explanation:
<b>b. Adults: Levels of Case Management Service</b> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No   If answered <b><u>NO</u></b> , please provide additional information:

# TARGETED CASE MANAGEMENT PROGRAM REFERRAL

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

**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: \_\_\_\_\_