City of Philadelphia Department of Behavioral Health and Intellectual disAbility Services
Division of Community Behavioral Health

CHILD CASE MANAGEMENT REFERRAL FORM

Children's Behavioral Health Case Management is a community-based service designed to assist children and their families in gaining access to community resources, services, and professionals whose functions are to provide the support, training and assistance required for a stable, safe, and healthy community life. The City of Philadelphia Department of Behavioral Health and disAbility Services has developed this referral form for Child Blended Case Management Services. Please use this form to apply for child case management services.

For a child to qualify for Case Management, they must meet the following Child Blended Case Management (BCM) medical necessity criteria:

Child BCM Medical Necessity Criteria

- Up to age 18, but if in high school and in special education, up to age 21.
- Primary mental health diagnosis within current DSM.
- Treatment history (shall be established when one of the following criteria is met):
  - Six or more days of psychiatric inpatient treatment in the past 12 months.
  - Without blended case management services, would result in placement in a community inpatient unit, state mental hospital, or other out-of-home placement, including foster care or juvenile court placements;
  - Currently receiving or in need of behavioral health services and receiving or in need of services from two or more human service agencies or public systems such as Education, Child Welfare, Juvenile Justice, etc.

INSTRUCTIONS FOR SENDING REFERRALS TO PROVIDER AGENCIES

- Please complete the application in its entirety.
- Choose one case management provider agency to send referral.
  - If referral is sent to multiple providers, this may delay start of services.
- If not typed, please print legibly, making sure the application is completed in its entirety. Illegible or incomplete forms will be returned.
- If email is unavailable to you, please call the provider for fax and/or mailing address.
- For a list of Child Case Management Provider Agencies, see the next page.

Submission of this application does not guarantee acceptance to a case management program.
Case Management Provider will notify you within 5 days regarding status of referral.

Blended Case Management Providers

Provider Name	Referral E-mail Address	Phone Number
CATCH, Inc.	Ccmrefer@catchinc.com	215-336-8933
Children Crisis Treatment Center (CCTC)	cctcbcm@cctckids.org	215-496-0707 ext. 1189
Children Crisis Treatment Center (Abriendo Caminos)	cctcbcm@cctckids.org	215-496-0707- ext. 1203
Children Crisis Treatment Center (Tamaa)	cctcbcm@cctckids.org	215-496-0707- ext. 1203
Community Council Health Systems	cbcmreferrals@cchss.org	215-473-7033
Consortium	cbcmreferrals@consortium-inc.org	512-748-7100
Hall Mercer	HMChildBCM@pennmedicine.upenn.edu	215-829-6463
Intercommunity Action, Inc. (INTERACT)	icacmreferral@intercommunityaction.org	215-487-1330 ext. 2004
Merakey	MerakeyChildBCM@merakey.org	215-203-5400
PaHrtners Deaf Services	Jessica.lamartin@rhanet.org	215-884-9770 x660; Video relay service: 866-327-8877
PATH, INC	ChildrenBCMreferrals@pathcenter.org	215-728-4602

Blended Case Management Autism Providers

Must have an Autism Diagnosis

Provider Name	**Referral E-mail Address**	**Phone Number**
Child Guidance Resource Center (CGRC)	SWPBCM@cgrc.org	267-713-4100
SPIN	spinbcmreferrals@spininc.org	267-784-5003

Children's Blended Case Management Referral Form

Child's Last name_____ First name _____

DOB _____ Gender _____ Race _____

SS#_____MA# _____

MA eligible: _____Yes_____No

Parent/guardian name_____ Relationship to child _____

Home address_____ City, State, Zip _____

Home phone # _____ Cell Phone #_____ Emergency Contact #_____

Current behavioral health diagnosis(es) per DSM-5 or ICD-10:

Is parent/guardian/child in agreement with this referral is being submitted? Yes_____No_____

Person completing form_____Title_____ Agency _____

E-mail address _____ Phone # _____ Date _____

Please provide information based on the past 6 months:

# Psych hospitalizations	_____	# Days in D&A rehab	_____
# Days in psych hospital	_____	# Days in juvenile detention	_____
# CRC\Police contacts	_____	# Days in RTF placement	_____
# 302 Commitments	_____		

If child was involved in any of the above services in the past 6 months, give dates and describe why:

Is child currently in an out-of-home placement?_____No _____Yes If yes, please check off type of placement:

____Hospitalization ____RTF ____Foster care ____other (please explain) _____

Provide name of placement (agency, family member or other) _____

Address of placement_____Phone Number_____

Why is child in out-of-home placement? _____

Anticipated discharge date from out-of-home placement _____

ALL INFORMATION MUST BE COMPLETED, INCLUDING THE ANTICIPATED DISCHARGE DATE

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LIVING ENVIRONMENT (answer all questions being asked)

1. What is current living environment? (Include: Who does the child live with, their relationship to child and how long have they lived at current residence)

2. Are there any stressors related to current living environment (Ex: chaotic living environment and why, child not properly supervised, drug infested neighborhood, home has bugs, family not able to pay their rent/mortgage, in danger of losing their home, etc.)?_____No_____Yes If yes, please explain.

3. Have there been any significant changes to the living environment in the past 2 years (Example: Child moved to grandparents' home 3 months ago, after mother passed away.)?
___No_____Yes, if yes please explain.

4. Are there any family members with significant needs (Provide information on family members that may have medical, behavioral health, Intellectual or Developmental Disorder, Substance Use Disorder, MR, D&A issues, etc.)?_____No____Yes If yes, please explain.

DHS/JJS INVOLVEMENT (answer all questions being asked)

1. DHS involvement: ___none ___supervision____custody
2. Juvenile justice system involvement: ___none ___probation ___JJ placement
3. If JJ placement, please select type:__ _ residential____community-based detention____JJ foster care
4. Provide DHS/CUA social worker and/or PO name and phone #

5. Provide description of why child is involved with DHS/CUA/JJS and when involvement began

EDUCATION (answer all questions being asked)

Child attends:_____ not in school ___ regular education ___ special education_ ___ Partial hospital program
Name of school/educational program_____Phone Number
If special education, specify type of classroom (Ex: emotional support, learning support, life skills, etc.): _____

BH services receiving in school (if any): STEP _____IBHS_____other_____

Provide description of behavior and needs for child in educational setting (Provide information on undesirable behaviors as well as positive behaviors):

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MEDICAL ISSUES/PHYSICAL DISABILITIES/MEDICATION (answer all questions being asked)

1. Describe child's medical issues.

2. List all medications, any medication issues or concerns. List whether or not child/family is compliant. Give the name and contact information of prescribing physician.

COMMUNITY/SOCIAL/PEER RELATIONS & STRENGTHS & STRESSORS

1. Provide list of involved and supportive people in the child's life.

2. Is child involved in community programs?_____No ____ Yes If yes, please list.

3. How does this child manage in the community, with peers and family?

4. What are this child's stressors?

NEED FOR BCM SERVICES (answer all questions being asked)

- What BH services is child currently receiving?

Service	Provider of service Name and phone number	Date started	How often provided	Actively participating In treatment?
				_____Yes_____No
				_____Yes_____No
				_____Yes_____No
				_____Yes_____No
				_____Yes_____No
				_____Yes_____No

Children's Blended Case Management Referral Form

This page must be completed

What current BH concerns justify this child receiving BCM services (are there acting out behaviors at home or school, suicidal ideation or attempts, etc.)? What services would you like BCM to assist with? (Provide specific behaviors)

PLEASE SEND FORM DIRECTLY TO YOUR SELECTED PROVIDER AGENCY

Referral will only be considered if all questions are answered completely.

FOR PROVIDERS ONLY **CBH Authorization**
ID#
Auth#
Date of auth