Dickinson Center, Inc.
Blended Case Management
Child/Adolescent Eligibility Criteria

Client Name: _____

DCI Chart #: _____ **DOB:** _____ **Social Security#:** _____

Address: _____ **Preferred phone#** _____
_____ Cell? Y / N

Parent Name: _____ **PH #** _____
or
Caregiver Name: _____ **PH #** _____

School: _____ **Grade:** _____

Please attach proof of behavioral health diagnosis (F code)

Examples include intake evaluation, psychiatric or psychological evaluation or Dr, RN or therapist note.

Please complete all sections.

Check all that apply.			
Children must meet criteria for diagnosis and treatment history	1. Diagnosis	**Behavioral Health diagnosis code**: Except for Primary Diagnosis of IDD, Psychoactive Substance Abuse, Organic Brain Syndrome or V-Code: please list F codes with Diagnosis:	
	2. Treatment History (Must meet one of these.)	i. Six or more days of psychiatric inpatient treatment in the past twelve months Where: Dates:	
		ii. Without Blended Case Management services the child would result in placement in a community inpatient unit, state mental hospital or other out-of-home placement, including foster homes or juvenile court placements	
		iii. Currently receiving or in need of mental 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. * **Please list agencies below**	

Current needs/reasons for referral. Please be specific as to what needs are:

Mental Health

Medical

Financial

ADL's

Social/Recreational

Drug & Alcohol

Educ./Vocational

Natural Supports

Housing

Legal

FAX COMPLETED PAGES (2) TO: (814) 776-0234
Please call Julie Papa with questions: (814) 776-0267

AGENCY INVOLVEMENT **Consumer Name:**_____ **DCI Char#:**_____

	Drug and Alcohol Issues	**Specify:**	
	Children and Youth Services	**Caseworker:**	**Phone:**
	Legal	**Probation Officer:**	**Phone:**
	Outpatient Therapy	**Therapist:**	**Phone:**
	Wrap Around Services	**Provider Agency:**	**Phone:**
	Therapeutic Staff Support Worker:		
	Mobile Therapist		
	Behavioral Specialist:		
	Prior Psychiatric Hospitalizations	**List:**	

Name of primary care physician: _____

Psychiatrist's Name:	
Agency:	
Telephone Number:	
Printed Name of Person Referring:	
Agency	
Telephone Number:	

_____ _____

Signature of Person Referring **Date**

This section to be completed by Case Management Staff.					
Date referral received:			**Received by:**		
Attempted Contacts	Date(s)	Phone/Face	Comments		
First Contact Date:		Type of Contact:		Contacted by:	
Comment:					
Intake date scheduled:			Kept? Y / N		

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6/20/22