Dickinson Center, Inc.

Blended Case Management
Adult Eligibility Criteria

DCI Chart# (if known) _____ **Date of Referral:** _____

Consumer Name: _____ **DOB:** _____

Address: _____

Preferred Phone # **Cell? Y/ N** **SS#**

Please attach proof of behavioral health diagnosis (F code)

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

CHECK ALL THAT APPLY AND SUPPLY DOCUMENTATION

Adults must meet criteria for Diagnosis **and** Treatment History	**1. Diagnosis**	i. **Behavioral Health diagnosis codes** (Except for Primary Diagnosis of IDD, psychoactive substance abuse, Organic brain syndrome or V-Code):	
	2. Treatment History (Must meet one of these.)	i. Six or more days of psychiatric in-patient care in the past 12 months: **Attach proof of hospital stay (when and where):**	
		ii. Met standards for involuntary treatment within the past 12 months. **Must attach proof.**	
		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 Drug and Alcohol, Vocational Rehabilitation, Criminal Justice, etc. (**** if checking this area, list two agencies:*** *)* 1 2	
		iv. At least 3 missed community mental health service appointments: Please provide dates:	
		or: Two or more face-to-face encounters with crisis intervention/emergency services personnel within the past twelve months	
		or: Documentation of non-compliance with medication for at least 30 days	

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

Mental Health		
Medical		
Financial		
ADLs		
Social		
Drug&Alcohol		
Edu/Vocational		
Natural Support		
Housing		
Legal		

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

Consumer name:_____ **DCI Chart#:**_____

	YES	NO
Is the consumer currently in services?		

Psychiatrist:
Address:
Therapist:
Address:

Printed name of person making referral: _____

Agency: _____

Phone: _____

Signature of person making referral: _____

*****Is person aware of this referral?:** Y N

TO BE COMPLETED BY CASEMANAGER:

******If Legal checked on previous page** On Probation? Y / N Pending legal issues? _____

☐ Individual has history of violence: **Detail** _____

☐ Household members have history of aggression/violence **Detail** _____

Does consumer have access to weapons? ☐ Yes ☐ No If so, what types? _____

Are the weapons secured? ☐ Yes ☐ No _____

Household Pets: Enter number of each: ☐ Dogs ☐ Cats ☐ Other _____

This section to be completed by Case Management Staff				
Date referral received:		**Received by:**		
Attempted Contacts	Date(s)	Time(s)	Phone/Face	Comments

First Contact Date:		Type of Contact:		Contacted by:	
Comment:					
Intake date scheduled:		Kept? **Y / N**	Opened / Declined		

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6/20/22