ARCHWAY STATION, INC.

45 QUEEN STREET • CUMBERLAND, MD 21502

REFERRAL for ADULT TARGETED CASE MANAGEMENT SERVICES (TCM)

Date of Referral: ______/______/______

Name: ____
First Middle Last

Telephone: (______) ______-________ (______) ______-________ (______) ______-________
Home Cell Other

Address: ____
Street City State Zip

DOB: ______/______/______ Age: ______ SS#: ______-______-______ Veteran: ☐ Yes ☐ No

Gender Identity:

☐ Male
☐ Female
☐ Choose Not to Disclose
☐ Male-to-Female (MTF)/Transgender Female/Trans Woman
☐ Female-to-Male (FTM)/Transgender Male/Trans Man
☐ Genderqueer, Neither Exclusively Male or Female
☐ Additional Gender Category or Other *(please specify)* ______________________________

Medical Assistance: ☐ Yes ☐ No **Medicare:** ☐ Yes ☐ No

Medical Assistance #: ______________________________ MCO *(if known)*: ______________________________

Please provide the name and telephone number of a person we can contact in case there is difficulty reaching the person being referred for services.

______________________________ (______) ______-________ ______________________________
Name Telephone # Relationship

Referral Source: ______________________________ (______) ______-________ ______________________________
Name & License/Credentials (if applicable) Telephone # Agency

Diagnosis: *To be eligible for services, the person must have a PBHS specialty mental health DSM-5 diagnosis which requires, and is likely to respond to, therapeutic intervention.*

____ ______________________
Diagnosis ICD-10 Code

____ ______/______/______
Provider Making Diagnosis (with credentials) Date of Diagnosis

The specific diagnostic criteria may be waived for <u>one</u> of the following two conditions:

☐ An individual committed as not criminally responsible who is conditionally released from a BHA facility
☐ An individual in a BHA facility or a BHA funded inpatient psychiatric hospital that requires community services. This excludes individuals eligible for Developmental Disabilities Administration's residential services.

<u>One</u> of the following criteria must be met for services:

☐ Are in, are at risk of, or need continued community treatment to prevent inpatient psychiatric treatment.
☐ At risk of, or need continued community treatment to prevent being homeless.
☐ At risk of incarceration or will be released from a detention center or prison.

FOR PEOPLE WITH MEDICAID:

One of the following criteria must be met for General Services. Two of the following criteria must be met for Intensive Services:

- ☐ Not linked to mental health and medical services
- ☐ Lacks basic supports for shelter, food, and income
- ☐ Transitioning from one level of care to another level of care
- ☐ Needs to maintain community-based treatment and services

FOR PEOPLE WITHOUT MEDICAID:

One of the following criteria must be met for General Services only:

- ☐ Has been discharged from a state mental hospital in the past 90 days
- ☐ Has been discharged from a mental health residential treatment facility within the last 12 months
- ☐ Has had more than one admission to a crisis stabilization unit (CSU), short-term residential facility (SRT), inpatient psychiatric unit, or any combination of these facilities within the last 12 months
- ☐ Is experiencing long-term and/or increasing acute episodes of mental impairment that may put him or her at risk of requiring intensive level of services

One of the following criteria must be met for General Services only:

- ☐ Currently being discharged from an inpatient psychiatric facility
- ☐ To prevent imminent hospitalization

Two of the following criteria must be met for General Services only:

- ☐ Must have an income of no more than 200% of the federal poverty level
- ☐ Must have an urgent need

If the person does not have Federally Funded Medicaid, we will need the following information in order to be able to submit a request for Uninsured Approval:

☐ Most recent Psychiatric or Psychosocial Evaluation (check box to indicate you have attached the evaluation)

Has the person applied for Medicaid? ☐ Yes, Date Applied: _____/_____/_____ ☐ No ☐ Unknown

Monthly Income: $__________ Income Source: __________________ # of Dependents: __________

Hx of Suicide Attempts:	☐Yes ☐No	Dates/Details:
Hx of Psychiatric Hospitalizations:	☐Yes ☐No	Dates/Hospital:
Hx of Clinical Deterioration:	☐Yes ☐No	Explain:
Hx of Arrests:	☐Yes ☐No	Dates/Locations/Charges:
Explain why the request is urgent. Include what else has been tried and what services were sought and denied:		

Targeted Case Management (TCM) services include:

1. Referrals to publicly available services for mental health, physical health, employment, food scarcity, housing, and/or entitlements and benefits.
2. Support with paperwork, prerequisites, and coordination of scheduling in order to begin those services.
3. Support with maintaining and making adjustments to those services in an effort to encourage continued use of services, if needed.
4. Support in planning for and transitioning to long-term continuation of services suited to the person's continuing needs in an effort to avoid future hospitalization or imprisonment (i.e. PRP or RRS, if needed).

Therefore, in addition to the information above, the person has the following urgent needs:

- ☐ Homelessness/At Risk for Homelessness
- ☐ Emergency Shelter
- ☐ Food
- ☐ Obtaining Mental Health Provider
- ☐ Obtaining Somatic Care Provider
- ☐ Dual Diagnosis Treatment
- ☐ Missed Mental Health Appointments
- ☐ Obtaining Official Documentation
  - ☐ Birth Certificate
  - ☐ Social Security Card
  - ☐ Identification Card
  - ☐ Other ________________________
- ☐ Assistance Applying for Benefits
  - ☐ Medical Assistance
  - ☐ SSI/SSDI
  - ☐ TDAP
  - ☐ SNAP (Food Stamps)
  - ☐ Energy Assistance
  - ☐ HUD
  - ☐ Other ________________________
- ☐ Assistance Applying for Employment or Obtaining Resources for Job Skills
- ☐ Other ________________________________

Primary Care Provider: ____

Mental Health Provider: ____

Reason for Referral & Additional Comments: (*Please provide as much information as possible)*

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Completed referrals can be submitted via fax or mail. Please send to the attention of 'Intake Coordinator'.
Fax to (301) 777-8020 or Mail to Archway Station, Inc., 45 Queen St., Cumberland, MD 21502.

FOR INTERNAL USE ONLY

Receipt of Referral:

Agency Received on: _____/_____/_____ Received By: _______ _____/_____/_____ Screened By: _______ _____/_____/_____

MA Verification:

Date Verified: _____/_____/_____ Verified By: ______________________________ ASO Check: ________________________

Eligibility: ____ Confirmation #: ______________________