



Service Access & Management, Inc.

Targeted Case Management (TCM) Referral

Date _____ Referring CM (if applicable) _____ County _____ BSU # _____

Referral Source and Contact Name _____ Phone _____

Priority of Referral: Emergent Urgent Routine TCM Preference: Male Female No preference Language Preference: English

Name: _____
First _____ M.I. _____ Last _____ DOB _____ Age _____

Address: _____

Phone: (H) _____ (C) _____ (W) _____ SS# _____

Parent/ Guardian/ POA: _____ Phone: _____

(documentation required for Guardian/POA)

Emergency Contact/Relationship: _____ Phone: _____

Funding Type: MH/DD CCBH/Perform Care MA Other _____
Specify _____

MA #: _____ Date Applied (if no MA): _____

MATRIX Score: _____ Date Completed: _____

Diagnosis:
Primary: _____

Additional: _____

DX Source: _____

Other Agency Involvement: _____

Current MH Services: _____

Involuntary Outpatient Commitment?: Yes No
Has Hypertension?: Yes No

Interest in Wellness Nurse Services?: Yes No
Smoker or Other Tobacco Use?: Yes No

Reason for Referral / High Risk Concerns: _____

Special Accommodations Requested: No Yes Specify: _____

Eligibility Criteria

Name: _____

Children's Targeted Case Management

(must meet one criteria in A and B)

A. Diagnosis

- Diagnosis within DSM IV (or succeeding revisions thereafter), excluding those with a principal diagnosis of Individuals with Developmental Disabilities, psychoactive substance abuse, organic brain syndrome, or a V-Code.

B. Treatment History (must meet one of the following):

- Six or more days of psychiatric inpatient treatment in the past twelve months.
- Without Targeted Case Management services, 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.
- 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.

C. Transition:

- A child or adolescent who currently receives intensive case management (ICM) or resource coordination (RC) services.

D. Waiver:

- A child or adolescent who needs to receive Targeted Case Management services; but, does not meet the requirements identified above, may be eligible for Targeted Case Management upon review and recommendation by the County Administrator or his/her designee, or the Behavioral Health Managed Care Organization, as applicable.

Adult's Targeted Case Management

(must meet on criteria in A and B)

A. Diagnosis

- Diagnosis within DSM IV (or succeeding revisions thereafter), excluding those with a principal diagnosis of Individuals with Developmental Disabilities, psychoactive substance abuse, organic brain syndrome, or a V-Code.

B. Treatment History (must meet one of the following):

- Six or more days of psychiatric inpatient treatment in the past twelve months.
- Met standards for involuntary treatment within the past twelve months.
- 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.
- At least 3 missed community mental health service appointments or two or more face-to-face encounters with crisis intervention/emergency services personnel within the past twelve months, or documentation that the consumer has not maintained his/her medication regimen for a period of at least 30 days.

C. Transition:

- Adults who received Resource Coordination, Intensive Case Management, or Blended Case Management services as children and were recommended by the provider and approved by the County Administrator or his/her designee or the Behavioral Health Managed Care Organization, as applicable, as needing Targeted Case Management services beyond the date of transition from child to adult.

D. Waiver:

- An adult who needs to receive Targeted Case Management services; but, does not meet the requirements identified above, may be eligible for Targeted Case Management upon review and recommendation by the County Administrator or his/her designee, or the Behavioral Health Managed Care Organization, as applicable.

Name: _____

- Approved
- Not Approved

Reason: _____

Referral Source Representative

Date

- Approved – criteria waived by MH/IDD Administrator

MH/IDD Administrator (*if applicable*)

Date

Name of TCM and Date assigned to TCM: _____

TCM Supervisor

Date