Targeted Case Management Referral Form

To type within the Referral, please single (left) click within the grey underlined box and start typing.

Demographics **Referral Date: _____**

Client Name: _______________________
Gender: *Male*☐ *Female*☐ *Trans* ☐ *Other, Please specify:*______ DOB: _____
Medical Assistance #: _____ No Insurance ☐
Address: ___________________________ Zip code: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

Ethnicity/Race

☐White ☐Native American ☐Black or African American ☐Asian
☐Hispanic, Latino, or of Spanish origin ☐ Native Hawaiian or Pacific Islander ☐Not Available
Primary Language: ___________________________
Are interpreter services required? Yes ☐ No ☐
☐ Deaf/Hearing Impaired
☐Blind
Special Accommodations needed: ____

Employment/Education

Employer: _____ Unemployed ☐
Education level: HS Graduate ☐ GED ☐ Some College ☐ Associate's Degree ☐ Bachelor's Degree ☐
No Diploma/Degree ☐

Current Residence

Private Residence ☐ Transitional Housing ☐ Homeless☐

Medical

Is the participant diagnosed with a medical condition?: ☐Yes ☐ No

☐ Obesity ☐ Asthma ☐ Diabetes ☐ High Blood Pressure ☐ COPD ☐ Other, please list: _____

Primary Care Physician or Medical Clinic: ________________________ Address: __________________________
Phone: ____________________
Mental Health

Please list DSM-5 Diagnoses and Codes / ICD-10-CM:
____
____
____

Diagnosis Given By: _____ Date: _____
Environmental/ Psychosocial Elements:
____

35 Kensington Pkwy
Abingdon MD 21009
Phone: (410) 671-2705 Fax: (410) 670-3010
leadingbyexamplellc@gmail.com

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____

Current Medication: None ☐
____
____
____

Please describe Reason for Referral and Symptoms and explain reason for level request:

Please indicate level of care:

Level I- General- 2 Units per month. Meets one of the following (please check):
☐ The participant is not linked to mental health and medical services
☐ Participant lacks basic supports for income, shelter, and food
☐ Participant is transitioning from one level of care to another level of care
☐ Participant needs case management services to obtain and maintain community-based treatment and services

Level II- Intensive- 5 Units per month. Meets two of the following (please check):
☐ The participant is not linked to mental health and medical services
☐ Participant lacks basic supports for income, shelter, and food
☐ Participant is transitioning from one level of care to another level of care
☐ Participant needs case management services to obtain and maintain community-based treatment and services

Release of Information (please have participant sign the release):

I understand that I am applying for Targeted Case Management in Harford County. This service has been explained to me and I understand that if approved I will participate in development of a care plan with a team of people working with me. I authorize the release of information to Leading By Example so they can conducted a full screening and initiate and eligibility determination by the Administrative Service Organization (ASO) to determine my eligibility for Targeted Case Management services. I understand that I may revoke my permission at any time by written or verbal request.

Signature of Client: ________________________________ Date: _________________________

Signature of Witness: ______________________________ Date: _________________________

Referral information
Referring individual: Agency:

Phone : Fax: Email :

Referral Source's Signature/ Credentials: ____