

Application for Adult Mental Health Case Management & Community Support Services

Behavioral Health Department

Medical Necessity Criteria for Admission (at least one item must be selected)	State reason(s) for selection:
<input type="checkbox"/> The applicant is at risk of or needs continued treatment to prevent inpatient psychiatric treatment.	
<input type="checkbox"/> The applicant is at risk of or needs community treatment to prevent being homeless.	
<input type="checkbox"/> The applicant is at risk of incarceration or will be released from a detention center or prison.	
<input type="checkbox"/> The applicant is a participant in the Continuum of Care Program (formerly known as "Shelter Plus Care").	HUD requires an individual who receives rental assistance via the Continuum of Care Program must receive case management services as long as rental assistance is provided to the individual.

The specific diagnostic criteria can be waived for the following two conditions:	
<input type="checkbox"/>	A participant committed as not criminally responsible who is conditionally released from a BHA facility, according to the provisions of health General Article, Title 12, Annotated Code of Maryland.
<input type="checkbox"/>	A participant in a BHA facility or a BHA-funded inpatient psychiatric hospital that requires community services. This excludes participants eligible for DDA's residential services.

Current Substance Use			
Type of Drug (Including Alcohol)	Date(s) Used	Amount	How Used (Smoked, IV, etc.)

Previous History of Substance Use			
Type of Drug (Including Alcohol)	Date(s) Used	Amount	How Used (Smoked, IV, etc.)

List current or last known psychiatric hospitalization:	
Name of Hospital/Facility	Date of Admission/Discharge

Medical Diagnoses (If applicable):	

Current Psychotropic Medications:		
Name of Medication	Dosage	Frequency

Application for Adult Mental Health Case Management & Community Support Services

Behavioral Health Department

Legal:

Has the applicant ever been arrested: Yes No

If yes, is the applicant currently on parole/probation: Yes No

Probation Agent's name:

Probation Agent's phone #:

Current charge(s):

Is the applicant currently on a Conditional Release Order: Yes No

CFAP Monitor's name:

CFAP Monitor's phone #:

Current Providers and Supports: (or most recent if not currently in treatment)

Name/Title:	Agency/Program	Contact Information:
Psychiatrist/Prescriber:		Telephone #: Fax #: Email:
Therapist/Clinician:		Telephone #: Fax #: Email:
Other Providers (Mobile Treatment/ACT, PRP, Supported Living, SEP, etc.)		Telephone #: Fax #: Email:
Substance Use Treatment Provider:		Telephone #: Fax #: Email:
Primary Care Physician:	Address:	Telephone #: Fax #: Email:
Emergency Contact:	Relationship to applicant:	Telephone #: Fax #: Email:

Current Income and Entitlements: If applicant has no income, check here:

Type of Income	Amount (Monthly)	Status
Supplemental Security Income (SSI)	\$	<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Pending
Social Security Disability Insurance (SSDI)	\$	<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Pending
Temporary Disability Allowance Program (TDAP)	\$	<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Pending
Veteran's Benefit (VA)	\$	<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Pending
Employment Earnings	\$	# of Hours Worked
Other Income: (Specify):	\$	<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Pending

Application for Adult Mental Health Case Management & Community Support Services

Behavioral Health Department

Type of Insurance	Insurance/Policy #	Status
Medical Assistance (MA)	#	<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Pending
Medicare (MC)	#	<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Pending
If NO insurance, please check: <input type="checkbox"/>		Does individual meet the criteria for Uninsured Eligibility ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Any additional information that you feel would be helpful in serving this individual:

Who is making this referral: Self Family Case Manager Other:

Contact Information of the person making referral (if not self):

Name:

Agency:

Phone:

Fax:

E-mail:

Referring Individual's Signature: _____

******DO NOT WRITE BELOW THIS LINE. HUMANIM USE ONLY******

Level I-General: Based on the severity of the participant's mental illness and if participant meets at least one of the following criteria

- Not linked to mental health and medical services
- Transitioning from one level of care to another
- Urgent If yes, describe:

- Lacks basic supports for shelter, food, and income
- Needs to maintain community-based treatment and services

Level II- Intensive: Based on the severity of the participant's mental illness and if participant *urgently* meets more than one

- Not linked to mental health and medical services
- Transitioning from one level of care to another
- Urgent If yes, describe:

- Lacks basic supports for shelter, food, and income
- Needs to maintain community-based treatment and services

Consent for Disclosure for Adult Case Management Services

I, _____, give my consent for the release of the following written information from _____ to the Humanim, Inc. (case management provider) for the purpose of determining eligibility for targeted case management services.

- | | |
|--|--|
| <input type="checkbox"/> Psychosocial assessment | <input type="checkbox"/> Substance Use history |
| <input type="checkbox"/> Psychiatric evaluation | <input type="checkbox"/> Legal history |
| <input type="checkbox"/> Psychological testing (if applicable) | <input type="checkbox"/> Individual Treatment or Rehabilitation Plan |
| <input type="checkbox"/> Physical\Health history | <input type="checkbox"/> Admission Summary |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Current or previous medications |
| <input type="checkbox"/> Income\Insurance | <input type="checkbox"/> Other: _____ |

Prohibition of Re-Disclosure: This information has been disclosed to Humanim, Inc. (case management provider) from your records whose confidentiality is protected. Any further disclosure is prohibited. This disclosure of information is effective until ____ / ____ / ____ (12 months from the date of your signature).

Applicant's Signature: _____

Date: ____ / ____ / ____

Witness's Signature: _____

Date: ____ / ____ / ____

Legal Guardian's Signature: _____
(If applicable)

Date: ____ / ____ / ____