Lehigh County Step By Step and Transitional Living Center (TLC) Referral Form

Please check ONE residential level of care:

Full-Care CRR * – Step By Step and TLC – 24 hr. staff
(check skills as needed below)

Moderate-Care CRR * – TLC – 10 hr. staff
(check skills as needed below)

Fairweather Lodge – Step By Step – minimal staff, manage own medications, must be drug & alcohol free for at least 1 year prior to application date, must be employed 20 hrs. / wk.
(check skills as needed below)

Life Skills Needed – UTILIZE ONLY FOR SERVICES ABOVE:

Budgeting	**Medications**
Cooking / Nutrition	**Money Management**
Daily Structure	**Personal Hygiene**
Housekeeping	**Public Trans / Mobility**
Interpersonal	**Safety Awareness**
Leisure Activities	**Shopping**
Managing Time	**Vocational / Educational**

Independent Apartments – Step By Step Congress and Woodward – no staff & unfurnished, must have income, must be drug & alcohol free for at least 1 year prior to application date

Date of Referral: ______________________

Referral Source:

Name: ______________________

Agency: ______________________

Address: ______________________

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Phone: ______________________

Email: ______________________

PLEASE NOTE:

*** Full Care and Moderate Care levels are transitional with average lengths of stay being 6-9 months.**

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Name: ______________________

Current Address: ______________________

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Current Living Environment: ______________________

Current Phone: ______________________

Date of Birth: __________ **SSN:** __________

Marital Status: __________ **Gender:** __________

Education (highest grade completed): ______________________

Emergency Contact: ______________________

Relationship: ______________________

Address: ______________________

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Phone: ______________________

Monthly Income: __________ **Source(s):** __________

__________ __________

(Select only one) BCM ACT Case Manager

Name: ______________________

Agency: ______________________

Community Psychiatrist: ______________________

Location: ______________________

Phone: ______________________

Diagnoses:

Primary Dx: ______________________

ICD-10 Code#: __________ - __________

Secondary Dx: ______________________

ICD-10 Code#: __________ - __________

Current Day Programming (i.e. – employment, school, volunteering, PHP, psych rehab, clubhouse, etc.):

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LEHIGH COUNTY **Magellan:** YES NO
Medicare: Yes - A B D NO

Outstanding medical conditions / physical limitations: ______________________

Other Insurance: ______________________

Representative Payee: ______________________ **Family Physician:** ______________________

Phone: ______________________ Phone: ______________________

Legal Charges (past and present): ______________________

Probation / Parole Officer Name: ______________________ Phone: ______________________

Drug and Alcohol History / Current Treatment: ______________________

DATE OF MOST RECENT USE: ______________________

Suicidal Behavior / Attempts: ______________________

History of Violence: ______________________

Symptomology: ______________________

Fire Setting History: ______________________

Past Agency / Hospital / Treatment Involvement:

Hospital / Agency / Treatment Facility Name:	Dates:

REASON FOR REFERRAL… PLEASE DESCRIBE DETAIL OF NEEDS BASED ON LEVEL OF CARE CHOSEN:

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PLEASE ALSO PROVIDE THE FOLLOWING:

A **Psychiatric Evaluation** *with in the last 12 months,* **OR** an older **Psychiatric Evaluation with recent treatment notes** *including current diagnosis.*

ALL REFERRALS NEED TO BE FORWARDED TO LEHIGH COUNTY FOR REVIEW:

Lehigh County MH/ID/D&A
Attn: CRR / Housing Liaison
17 S 7th Street
Allentown PA 18101
FAX#: 610-820-3689 OR 610-871-1455

CRR/LODGE/INDEPENDENT APT. REFERRALS NEED TO BE FORWARDED TO THE APPROPRIATE AGENCY:

Step By Step
Attn: Intake Personnel
2015 Hamilton St.
Suite 103
Allentown PA 18104
FAX#: 610-882-2497

Transitional Living Center
Attn: Intake Personnel
264A Levan St
Allentown PA 18102
FAX#: 610-841-5324