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)

◯ **Independent Rooms** - Salisbury Behavioral Health - minimal staff, manage own medications, sober-living, community participation 15 hours per week, source of income required - In an effort to be environmentally friendly, referrals to the independent rooms will be screened and then forwarded to Salisbury Behavioral Health by Lehigh County.
(check skills as needed below)

Life Skills Needed – UTILIZE ONLY FOR SERVICES ABOVE:

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

Date of Referral: _____

Referral Source:

Name: _____

Agency: _____

Address: _____

_____

_____

Phone: _____

Email: _____

◯ **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

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Name: _____

Current Address: _____

_____

Current Living Environment: _____

Current Phone: _____

Date of Birth: _____ **SSN:** _____

Marital Status: _____ **Gender:** _____

Education (highest grade completed): _____

Emergency Contact: _____

Relationship: _____

Address: _____

_____

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.):

_____

_____

_____

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:

_____

_____

_____

_____

_____

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
Bethlehem PA 18018
FAX#: 610-882-2497

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

☐ **Independent Rooms**
Lehigh County MH/ID/D&A
Attn: CRR / Housing Liaison