Lehigh County Residential Programs Referral Form

In an effort to be environmentally friendly, referrals to the long term residential programs listed below will be screened and then forwarded to the appropriate agency by Lehigh County.

Please check ONE residential level of care:

Date of Referral: ______________________

- ○ **Resource for Human Development** – Community Residential Rehabilitation - Hope Springs
- ○ **Merakey** – Enhanced Personal Care Home
- ○ **Merakey** – Enhanced Community Residential Rehabilitation
- ○ **Salisbury Behavioral Health** – Enhanced Personal Care Home – Acorn
- ○ **Salisbury Behavioral Health** – Supported Housing
- ○ **Step By Step** – Long Term Structured Residence – Forensic
- ○ **Step By Step** – W Congress Supported Housing – Forensic
- ○ **Step By Step** - Community Residential Rehabilitation

Referral Source:

Name: ______________________

Agency: ______________________

Address: ______________________

____

Phone: ______________________

Email: ______________________

Life Skills Needed

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

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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: ______________________

____

Phone: ______________________

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

__________ __________

Representative Payee: ______________________

Phone: ______________________

(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. – work, school, volunteering, PHP, psych rehab, etc.):

____

____

____

LEHIGH COUNTY Magellan: YES ◯ NO ◯ **Outstanding medical conditions / physical limitations:**

Medicare: Yes - ◯ A ___ B ___ D ___ NO ◯

Other Insurance: _____

Family Physician: _____ Phone: _____

Legal Charges (past and present): _____

If currently incarcerated: current and past misconducts/segregation: _____

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 & Address: Dates:

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

PLEASE ALSO PROVIDE THE FOLLOWING:

☐ A **Psychiatric Evaluation** within the las 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