

TARGETED CASE MANAGEMENT PROGRAM
Pre-Screening
Wicomico County Core Service Agency

CONSENT FOR CASE MANAGEMENT SERVICES
AND RELEASE OF INFORMATION

Name: _____

Address: _____

Telephone: _____ DOB: _____

Referring Agency: _____

Agency Contact Person: _____ Phone: _____

Consent to Services:

I understand that I am applying for case management services for the Targeted Case Management Unit of Wicomico County Health Department. I agree to receive these services if approved and to participate in the development of a Service Plan, which I will be asked to sign. I understand that I may revoke my consent to services at any time by written or verbal request.

Consumer Signature (or guardian): _____ Date: _____

Witness: _____ Date: _____

Information Release:

I authorize the above referenced referring provider to furnish to the Wicomico County Core Service Agency, the information requested on the Targeted Case Management Program Pre-Screening and the Targeted Case Management Referral forms for review. This information will be used to make a pre-determination of eligibility for case management services. If found eligible for services, I further authorize the release of this information to the Wicomico County Health Department's Targeted Case Management Unit for full screening and service eligibility determination and to the ASO to determine eligibility for Targeted Case Management services. I understand that I may revoke my permission at any time by written or verbal request.

Consumer Signature (or guardian): _____ Date: _____

Witness: _____ Date: _____

WICOMICO BEHAVIORAL HEALTH TARGETED CASE MANAGEMENT

REFERRAL/FACT SHEET

Name: _____ SSN: _____

Address: _____ MA #: _____

_____ Phone: (_____) _____

DOB: _____ Age: _____ Marital status: _____ Race: _____ Sex: _____

Referral Source: _____ Phone: (_____) _____

Emergency Contact: Name: _____

Address: _____

_____ Phone: (_____) Relationship: _____

Reasons for Referral (Describe in Detail): _____

Suicidal Ideation/Behavior _____ YES _____ NO

Aggressive Ideation/Behavior _____ YES _____ NO

Please Describe in Detail: _____

Current Psychiatrist or Therapist: _____ Phone(____) _____

DSM IV Diagnosis: Axis I: _____

****include dx. Code #**

& Mental Status Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Current Signs and Symptoms of Diagnosis _____

Medications: _____

Previous Psychiatric Treatment (date and # of years and number of inpatient admissions):

Is client currently receiving or been referred for PRP services? _____

Is yes, please justify need for both PRP and TCM services: _____

Current Substance Use/Abuse: (facility and where are they being treated)

Previous Substance Abuse Treatment: _____

Social History:

Living Situation: (with whom) _____

Employment/Financial support: _____

Education: _____

Military: _____

Legal History:

Reason for involvement with criminal justice system and referral to Targeted Case Management: _____

of incarcerations and dates _____

on probation and reason why on probation _____

Current Legal Charges:

Charge	Date	Outcome

Bond _____ Parole _____ Yes _____ No _____ Probation _____ Yes _____ No _____

Attorney _____ Phone (_____) _____

Parole/Probation Officer: _____ Phone(_____) _____

Signature of Person Completing Form Date: _____

_____ Accepted

_____ Declined Reason: _____ Referral to: _____

Wbhtcm 02/08mb

*****Mental Health Diagnosis must be from a mental health provider or a licensed individual able to diagnose. There must be an appropriate DSM IV code. It should be no older than 1 year since the diagnosis was given. The individual claiming to have a mental health diagnosis is not sufficient for the referral. If at all possible a mental status evaluation should be sent with the referral.*****