Choice. Respect. independence.

Adult Care Coordination (Case Management) Referral Form

Please fax this completed referral form to **(410) 760-6670**

Please include any psychosocial history and/or diagnostic information along with referral.

About the person who needs services:

Full Name		
Phone Number		
Mailing Address		
City	State	ZIP Code
County: ☐ Anne Arundel County ☐ Baltimore County ☐ Montgomery County		
Date of Birth	Social Security Number	
Gender/Race/Ethnicity	Marital Status	
Name of Insurance	Member Number	
Does the person have Medicaid? ○ Yes ◉ No	Does the person have Medicare? ○ Yes ◉ No	
Is Medicaid coverage active now? ○ Yes ◉ No	If not, has person applied? ○ Yes ◉ No	

Diagnosis: Complete or attach documentation.

ICD 10 Code	Diagnosis
ICD 10 Code	Diagnosis
ICD 10 Code	Diagnosis
Who made this diagnosis? Include credentials.	
Has the person ever had a **substance use disorder**? ○ Yes ◉ No (If yes, list diagnosis above.)	
If yes, drug(s) of choice	
If yes, date of last use	

Recent Psychiatric Hospitalization(s)

Date	Name of Hospital	Reason for Hospitalization
Date	Name of Hospital	Reason for Hospitalization

Reason for the referral – client must meet the clinical criteria for at least one of the following

Is the person currently at risk of, or in need of case management to prevent:

- ☐ Inpatient Hospitalization
- ☐ Homelessness
- ☐ Return to restrictive environment, i.e., recently released from correctional/institutional setting

Please explain:

Please check if the person:

- ☐ Has received services in the public mental health system at any time in the past two years.
- ☐ Is receiving SSI/SSDI for mental health reasons.
- ☐ Must receive services as required by an order of conditional release and/or NCR

About the person making the referral:

Name of person making the referral. Please include your credentials.		
Agency		
Mailing Address		
City	State	ZIP Code
Telephone Number	Fax Number	
E-mail		
Date		
Any other comments?		

Thank you for referring this person to Community Residences. When we receive this fax, we will call the person to schedule an assessment. If we determine that we cannot offer our services to this person, or we have difficulty contacting the person, we will inform you.

Please call us at **(410) 760-2250** if you have any questions.