To be completed upon receipt by Case Management Office					
Agency		**Date Referral Received**		**Date Referral Assigned**	

County of Chester
Child and Adolescent Blended Case Management
Referral Application Form

County of Chester offers a range of case management services for children that are supportive and aimed at promoting resiliency. While services vary in level of support, this referral application will help to identify the appropriate level support that will meet the child and family goals. This application is to be completed in partnership by the youth/family and referral source.

A psychiatric/psychological evaluation completed within the last six months must accompany this referral.
Please forward referral to appropriate case management office (list attached).

Youth Information Date of Referral:_____

First Name: _____Middle Initial: ___ Last Name _____

DOB:_____ Ethnicity: _____Sex: _____SS#_____BSU#:_____

Address and Contact Phone Numbers:

Address: _____ Home#: _____
_____ Cell#: _____

Youth's Insurance

☐ Private Insurance: _____
Group#: _____ Policy#:_____

☐ Medical Assistance
CCBH Yes ☐ No ☐ Pending ☐
Physical Health Provider _____

Parent Information

Mother _____ Father _____
Home Phone _____Home Phone _____
Cell _____Work_____ Cell _____Work _____
Mother - Physical Custody ☐ Yes ☐ No Father – Physical Custody ☐Yes ☐ No
Mother – Legal Custody ☐ Yes ☐ No Father – Legal Custody ☐Yes ☐ No

****If parents do not have physical or legal custody, please identify guardian***
Guardian: _____ Relationship: _____
Address: _____Contact#: _____

Household Information

Name	Age	Relationship	Do they receive MH services? (describe)

Cultural Considerations (language, ethnicity, religion, etc.)

DSM Diagnosis

_____ **Code:**_____
_____ **Code:**_____
_____ **Code:**_____
_____ **Code:**_____
_____ **Code:**_____

Physical and Psychiatric Medications (please include name and dosages)

Primary care Physician

Doctor _____
Practice_____
Address_____ Phone_____
Date of last physical* _____
Allergies _____

*attach copy of available

Inpatient Psychiatric Hospitalizations

Facility	Date	Reason for Admission

Community Support

Please check all services that the youth has had previous involvement with and if the youth is currently receiving the service **please provide agency name, staff contact and phone**.

Service	Date(s)	Currently Involved	
Outpatient		YES ☐ Agency: _____ Staff Contact: _____ Phone:	NO ☐
Behavioral Health Rehabilitation Service		YES ☐ Agency: _____ Staff Contact: _____ Phone:	NO ☐
Transition to Independence Process		YES ☐ Agency: _____ Staff Contact: _____ Phone:	NO ☐
Multisystem Therapy		YES ☐ Agency: _____ Staff Contact: _____ Phone:	NO ☐
Parent Child Interactive Therapy		YES ☐ Agency: _____ Staff Contact: _____ Phone:	NO ☐
Dialectical Behavioral Therapy		YES ☐ Agency: _____ Staff Contact: _____ Phone:	NO ☐
Family Based Services		YES ☐ Agency: _____ Staff Contact: _____ Phone:	NO ☐
Partial Hospital		YES ☐ Agency: _____ Staff Contact: _____ Phone:	NO ☐
Therapeutic Foster Care		YES ☐ Agency: _____ Staff Contact: _____ Phone:	NO ☐
Residential Treatment Facility		YES ☐ Agency: _____ Staff Contact: _____ Phone:	NO ☐
Substance Use		YES ☐ Agency: _____ Staff Contact: _____ Phone:	NO ☐
High Fidelity Wraparound		YES ☐ Agency: _____ Staff Contact: _____ Phone:	NO ☐

Community Supports (Continued)

Service	Date	Currently Involved	
Office of Developmental Disabilities		YES ☐ Agency: _____ Staff Contact: _____ Phone:	NO ☐
Office of Children & Youth		YES ☐ Agency: _____ Staff Contact: _____ Phone:	NO ☐
Juvenile Probation Office		YES ☐ Agency: _____ Staff Contact: _____ Phone:	NO ☐
Other		YES ☐ Agency: _____ Staff Contact: _____ Phone:	NO ☐

School Information

School:_____ Grade: _____
Contact Person: _____ Phone: _____
School District: _____

☐ IEP/504 Plan (check if applicable)
☐ Graduated High School (check if applicable)

Referral Source

Name_____ Title _____ Phone _____
Agency Address _____

Contact with Referral Source YES ☐ NO☐
Comments: _____

Reason for Case management Referral
How would the youth benefit from case management services? What are their needs surrounding medical, social, housing, education, and other services?

Signature (if over age 14) Parent/Guardian Signature

_____Date _____ _____Date _____

Printed Name (if over age 14) Parent/Guardian Printed Name

_____Date _____ _____Date _____

Packets can be faxed to the following providers. Please check the box of each provider the referral is being sent to:

☐ **Child/Adolescent Case Management Unit – Human Services**
520 E. Lancaster Ave
Downingtown, PA 19335
Fax: 610-873-3317

☐ **Child/Adolescent Case Management Unit – Community Service of Devereux**
1041 West Bridge Street
Phoenixville, PA 19460
Fax: 610-933-7451

☐ **Child/Adolescent Case Management Unit- Child Guidance Resource Center**
744 East Lincoln Highway
Suite 420
Coatesville, PA 19320
Fax: 610-383-6581