

**Dickinson Center, Inc.  
Mental Health Case Management  
Adult Eligibility Criteria**

BSU Number: \_\_\_\_\_  CCBH  Other Insurance

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Social Security #: \_\_\_\_\_

**Please attach proof of diagnosis (Axis I - V, within the past year) Examples include intake evaluation, psychiatric or psychological evaluation or Dr, RN or therapist note.**

**Please complete all sections.**

Check all that apply.			
Group A (Adults who meet criteria for Diagnosis, Treatment History AND Functioning Level)	Diagnosis	DSM IV R Diagnosis Except for Primary Diagnosis of MR, psychoactive Substance Abuse, Organic Brain Syndrome or V-Code	
	Treatment History (Must meet one of these.)	Six or more days of psychiatric inpatient in past 12 months	
		Met standards for involuntary treatment within the past 12 months	
		Currently receiving or in need of mental health services and receiving or in need of services from two or more human service agencies or public systems such as Drug and Alcohol, Vocational Rehabilitation, Criminal Justice, etc.	
		At least 3 missed community mental health service appointments, or two or more face-to-face encounters with crisis intervention/emergency services personnel within the past 12 months, or documentation that the consumer has not maintained his/her medication regimen for a period of at least 30 days	
Functioning Level	GAF ≤ 60		

**Agencies Currently Involved with Client:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Reason for Referral:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FAX COMPLETED PAGES (2) TO: DENISE TUTTON (814) 776-0234  
Please call with questions: (814) 772-2005 ext. 429**

Medications: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Dates and Location of Recent Hospitalizations: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Income Resource:**

SSI    SSDI    Cash Assistance    Other \_\_\_\_\_

**Insurance:**

Access    Medicare A    Medicare B    Medicare D    Other \_\_\_\_\_

<b>Psychiatrist's Name:</b>	
<b>Address:</b>	
<b>Telephone Number:</b>	
<b>Printed Name of Person Referring:</b>	
<b>Name of Referring Agency:</b>	
<b>Address of Referring Agency:</b>	
<b>Telephone Number:</b>	

\_\_\_\_\_  
**Signature of Person Referring**

\_\_\_\_\_  
**Date**

This section to be completed by Case Management Staff.				
<b>Date referral received:</b>		<b>Received by:</b>		
<b>Attempted Contacts</b>	Date(s)	Phone/Face	Comments	
First Contact Date:		Type of Contact:		Contacted by:
Comment:				

revised 4/20/10

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