

**Dickinson Center, Inc.  
Blended Case Management  
Child/Adolescent Eligibility Criteria**

Client Name: \_\_\_\_\_  CCBH  Other Insurance

BSU Number: \_\_\_\_\_ DOB: \_\_\_\_\_ Social Security#: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Address: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Address: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Principal: \_\_\_\_\_ Teacher: \_\_\_\_\_ Guidance Counselor: \_\_\_\_\_

**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.**

<b>GROUP A</b> Children who meet criteria for Diagnosis, Treatment 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 treatment in the past twelve months	
			Without Blended Case Management services the child would result in placement in a community inpatient unit, state mental hospital or other out-of-home placement, including foster homes or juvenile court placements	
			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 Education, Child Welfare, Juvenile Justice, etc.	
<b>Functioning Level</b>		GAF ≤ 70		

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

## AGENCY INVOLVEMENT

	<b>Drug and Alcohol Issues</b>	<b>Specify:</b>	
	<b>Children and Youth Services</b>	<b>Caseworker:</b>	<b>Phone:</b>
	<b>Delinquent Behaviors</b>	<b>Probation Officer:</b>	<b>Phone:</b>
	<b>Outpatient Therapy</b>	<b>Therapist:</b>	<b>Phone:</b>
	<b>Wrap Around Services</b>	<b>Provider Agency:</b>	<b>Phone:</b>
		<b>Therapeutic Staff Support Worker:</b>	
		<b>Mobile Therapist</b>	
		<b>Behavioral Specialist:</b>	
	<b>Prior Psychiatric Hospitalizations</b>	<b>List:</b>	
	<b>Currently Prescribed Medications</b>	<b>List:</b>	

<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>	<b>Date(s)</b>	<b>Phone/Face</b>	<b>Comments</b>	
<b>First Contact Date:</b>		<b>Type of Contact:</b>		<b>Contacted by:</b>
<b>Comment:</b>				
<b>FAX COMPLETED PAGES (2) TO: DENISE TUTTON (814) 776-0234</b> <b>Please call with questions: (814) 772-2005 ext. 429</b>				