WASHINGTON COUNTY HEALTH DEPARTMENT
Division of Behavioral Health Services

State Care Coordination Application

Date: _____ PRF: _____ (completed by WCHD staff)

Referring Agency: _____ Contact Person (if applicable): _____

Referring Agency Phone Number: _____ Agency Fax Number: _____

Referring Agency Address: _____

Demographics of the Individual being referred to WCHD for services:

Name: _____DOB: _____
First Middle Last

SSN: _____

Address: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Patient Pregnant? ___ No ___Yes Due Date: _____

IV Drug Use Within Last Five Days? ___No ___Yes

Birth Sex: ___Female ___Male

Gender Identity: ___No Disclosure ___FTM Transgender ___Gender Queer ___Female ___Male ___MTF Transgender ___Something Else

Preferred Language: ___English ___Spanish ___Other: _____ Limited English Proficiency: ____No ____Yes

Race: ___American Indian / Alaska Native ___Asian ___Black or African American ___ Declined to specify

___Native Hawaiian or Other Pacific Islander ___White

Ethnicity: _____Declined to Specify ___Hispanic or Latino ___Not Hispanic or Latino

Marital status: ___ Single ___ Married ___ Separated ___ Divorced ___ Widowed

Presenting Problems:

_____

Patient is in urgent need of immediate care:

_____

Employment Status: _____

Substance Use and Mental Health Diagnosis:

ICD-10	DSM-5 Diagnosis
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Substance Use History:

Date of last use: _____ Substance used: _____

Date of last use: _____ Substance used: _____

Date of last use: _____ Substance used: _____

Longest Period of Sobriety: _____

Previous Treatment: _____

_____

_____

What type of treatment services is the individual engaged with currently:
(Please check all that apply)

_____ Inpatient substance use
_____ Residential substance use
_____ Outpatient substance use
_____ Outpatient mental health

Name of Provider: _____

Name of Assigned Counselor: _____ _____-_____-_____
Name and Credentials Phone Number

Treatment modality: _____ Groups sessions per week
_____ Individual sessions per week
_____ Medication Assistance Treatment (MAT)
_____ Other

Participant's long-term treatment goal: _____
_____
_____

Will the participant be discharged from services in the upcoming weeks? ___ Yes ___ No
Date of anticipated discharge: _____
If yes, please describes referrals made to include linkage to aftercare treatment services:
_____
_____
_____

Does the participant need case management in the following areas: (Please check all the applies)?

Identification

____Needs Identification card or license
____Needs Social Security Card for self
____Needs Birth Certificate(s)
____Other: _____

Financial

____Apply for entitlements through the local Department of Social Services
____Needs to establish a budget and/or bank account
____Other: _____

Substance Use

____Wants workbook/reading material
____Wants resources on community support meetings
____Wants to obtain a community support sponsor
____Other: _____

Medical

____Needs a primary care physician
____Needs a pediatric physician for children
____Needs appointment with a specialist
____Needs to establish medical insurance
____Other: _____

Mental Health

____Needs a mental health assessment
____Needs referred for psychiatric care
____Interested in community based mental health case management services
____Wants workbook/reading material
____Other: _____

Employment

___Wants to enroll in GED classes
___Needs to make a resume
___Needs to start seeking employment
___Wants to apply for disability
___Needs referred to Western Maryland Consortium
___Other: _____

Legal

___Has outstanding warrants
___Has court on: _____
___Has probation officer: _____
___Has or needs an attorney: _____
___Other: _____

Housing

___Needs to apply for housing assistance
___Needs to determine plans for housing
___Other: _____

Support System

Current Supports: _____

___Wants to establish a network of supports in the community

___Wants to improve relationships with support system

___Wants to engage in family therapy

___Other: _____

Parenting

____Needs or wants parenting classes in the community

____Wants reading material on parenting skills

____Needs childcare vouchers from the Dept. of Social Services

____Needs to establish childcare plan

____Other:_____

Other needs not listed:

1. _____
2. _____
3. _____
4. _____

Please submit the individual's discharge summary and treatment plan if available

_____ _____

Participant Signature, if available Date

_____ _____

Staff Signature Completing Form Date

Dev.: 8/20