

Adult Consumer Identification Form (Instructions)

**IMPORTANT: This form must be accompanied by a recent Psychiatric Evaluation
(Within past 6 months) and an MA Eligibility Verification Slip (EVS)**

CURRENTLY REQUESTING (Checking one):

Behavior Health Intellectual Disability: Consumer is not currently receiving TCM services, but is requesting BHID/TCM immediately.

Target Case Management: Consumer is not currently receiving TCM services, but is requesting TCM immediately.

TCM Discharged: Consumer is currently receiving TCM services, but is requesting discontinuation of TCM services.

Include closure code and explanation in Additional Comments section on last page.

TCM Transfer: Consumer is currently receiving TCM services, but is requesting TCM at another agency (*may include change in LOC*).

CONSUMER DEMOGRAPHICS:

Consumer Name (Last/First/Initial): Please print one letter in each block (*No nicknames*).

Address: Consumer's permanent address

Consumer Phone Number:

Ethnicity Code: (1) Caucasian (2) African American (3) Latino (4) Asian (5) Other/Specify

Date of Birth: Include full year (e.g. 1967)

BSU Status: Enter BSU number and Access Card Number

Insurance Carrier: The consumer's Physical Health HMO. Include "Private" or "Ma". If consumer is uninsured, write NONE.

Income Status: Consumer's income status (SSI, SSA, SSDI, VA, Name of employer, etc.)

Name of Payee: Name of person officially designated to receive SSI, SSDI or other payments.

Amount per month: Consumer's monthly income

CURRENT HOSPITALIZATION/ INCARCERATION:

Facility: If the consumer is currently hospitalized or incarcerated, provide the name of the hospital or jail.

Admit/Discharge Date: Enter the admission date and anticipated discharge date (if known).

Contact Name/Phone: Name and number of hospital or prison contact person. If incarcerated please provide the PP#

ICD 10 CM DIAGNOSIS:

Use axis code from ICD9/DSM IV TR Manual and written diagnosis.

Axis codes must match those recorded on the accompanying psychiatric evaluation.

PRESENTING PROBLEMS:

Explain why the consumer needs BHID level of services. Provide detailed information of what symptoms/behaviors the participant has related to their severe and persistent mental illness that needs to be addressed.

Definition of Severe and Persistent Illness:

- Persistent Mental Illness (SPMI): This term is sometimes used to describe schizophrenia, schizoaffective disorder, recurrent major depression and bipolar disorder. The word “severe” refers to degree in which the illness may disrupt a person’s normal life activities. The word “persistent” refers to the long duration of these illnesses.

BEHAVIORAL HEALTH TREATMENT HISTORY

CRC/MET visits

Involuntary Commitments	Enter number of approved petitions for involuntary psychiatric treatment.
Times Hospitalized	Enter number of times the consumer was admitted to a psychiatric hospital.
Days Hospitalized	Enter the number of days of psychiatric inpatient care for each period.
Detox Episodes	Enter the number of times the consumer entered detoxification treatment.
Days in D&A Rehab (Residential)	Enter the number of days of residential D&A rehab for each period.
Days in D&A Rehab (Out Pat.)	Enter the number of days of outpatient D&A rehab for each period.
Days Incarcerated	Enter the number of days in a jail, prison or other correctional facility.

PSYCHOSOCIAL HISTORY-Problems, barriers and potential interventions that explain the need for requested TCM services.

1. Stable Living Environment: Use the codes below to define the type of living situation.

- | | |
|--|--|
| 1-Living Alone (Independently) | 14-General/VA Medical/Surgical Ward |
| 2-Living with Others (Largely Independent) | 15-Nursing Home |
| 3-CRR Minimum Supervision | 16-Genenal/VA Psychiatric Ward |
| 4-Personal Care Home | 17-Inpatient/Residential IDD Program |
| 5-Domiciliary Care or Foster Care | 18-Private Psychiatric Hospital |
| 6-Living with Others (Largely Dependent) | 19-Extened Acute Care Unit |
| 7-Living Alone (Largely Dependent) | 20-State Mental Hospital |
| 8-Supported Living | 21-Single Room Occupancy Hotel |
| 9-CRR Moderate Supervision | 22-Shelter/Mission/Progressive Demand |
| 10- CRR Maximum Supervision | 23-Criminal Detention (SCI, County Jail, Other) |
| 11-CRR Intensive Maximum Supervision | 24-Other Institutional Setting (Not Specified Above) |
| 12-Long Term Structured Residence | 25-Living with Family |
| 13-ID-CLA | 26-Life Sharing |
| | 27-Homeless |

2. **Residential History**- answer questions about consumers residential history. Provide detailed information in the statement area addressing the consumer's current housing status. List and explain any barriers that currently place consumer's residential stability at risk. Check the type of housing that applies.
3. **Substance Use/Abuse Issues**: Detailed substances used/abused, frequency of use, first and last time used, method, current treatment, and longest period of sobriety.

4. **Meaning Daily Activity**: Use codes below to find the type of educational/vocational activity in which the consumer is correctly involved.

- | | |
|---|---|
| 1-Competitive Private Sector Employment
(21+hrs/wk.) | 11-Transitional Employment (20 or less hrs. /wk.) |
| 2-Attending College (7+ credit hrs.) or High School | 12-Attending College (6 or less hrs. /wk.) |
| 3-Remains at home to care for Dependents | 13-Actively Seeking Employment |
| 4-Competitive Private Sector Employment
(20 or less hrs. /wk.) | 14-Attending Vocational School/ Training |
| 5-Retired (60+) | 15-Basic Academic Preparation (GED) |
| 6-Supported Employment (21+ hrs. /wk.) | 16- Screening and Evaluation |
| 7-Supported Employment (20 or less hrs. /wk.) | 17-Sheltered Employment |
| 8-Affirmative Industry Employment (21+ hrs. /wk.) | 18-Ongoing Volunteer Work |
| 9- Affirmative Industry Employment (20 or less hrs. /wk.) | 19-Sheltered Workshop |
| 10-Transitional Employment (21+ hrs. /wk.) | 20-Prevocational Training |
| | 21-No Vocational or Educational Activity |

a-d): Rate the consumer's daily activity, ability to use resources, ability to access, and ability to plan.

e & f :) List consumer's self-report of current in-home and out-of-home activities and interests.

5. Educational/Vocational History

Answer questions about educational and vocational history. Provide detailed information in the areas that require a statement. Attach any documentation of education/vocational/involvement
i.e. certificate of completion, GED, high school diploma.

6. Medication Regimen:

a-i): Describe the consumer's medication regimen, and list what resources the consumer has in place to ensure these medications are taken properly.
Attached most recent Medication Administration Record, if applicable.

7. Medical History:

Answer the question about the consumer's current medical and dental issues. Be specific when listing past medical procedures, diagnosis, and hospitalizations. Include names, dates of treatment, and location of treatment.

8. Medical Issues/Physical Disabilities:

List any medical issues or physical disabilities. Check the appropriate level of severity and whether the consumer had recent treatment.
a-d: Describe how these medical or physical issues affect daily living and what, if anything would constitute the need for TCM support.

9. Behavioral Risk Factors:

Describe any behavioral risk factors that relate to the consumers and which, if any, would constitute the need for TCM support.

10. Current Consumer Support:

Answer questions about the consumer's current social, peer supports (i.e. family, friends, clubs, drop-in centers, etc.)

11. Family Information

List any information about the family (include addresses and phone numbers).

12. Forensic System Involvement

a-c): Explain the consumer's current or past history of incarceration and /or parole. Include the name and phone number of the parole or probation officer (if known.) and any active court cases (include next court date if applicable)

Additional Comment:

Explain why you believe that the person needs mental health case management services. How can a case manager help in this situation? Be very specific. Include any information regarding the individual's guardianship or Power of Attorney

Person Completing This Form

Your name, title, the organization you work for, the agency address the telephone and the date the form is completed. The contact person is needed, if different from the person completing the form. Include attending physician and where practice is located.

Consumer's Signature: *Because the service is voluntary, the consumer must sign this form for proof of informed consent.*

Scan original application with supporting documents to cmreferrals@pmhcc.org &

Mail the completed application with attached documentation to DBHIDS attention Shawn Evans, 701 Market Street, 5th floor, Philadelphia Pa, 19106