Mental Health America of South Carolina

Bridges Clubhouse

Case Manager Client Referral Check List

Client Name: _____

Client Phone Number: _____

Case Manager Name: _____

Case Manager Phone Number: _____

To expedite your clients' intake process, please provide the following with the referral packet:

☐ **Current Medication List**

☐ **Current Diagnosis (F Code)**

☐ **Copy of Insurance Card (Front and Back)**

☐ **Court Order (If Applicable)**

☐ **Legal Guardianship Order (If Applicable)**

MENTAL HEALTH AMERICA OF SOUTH CAROLINA (MHASC)

SUPPLEMENTAL REFERRAL FORM

DATE: _____ PROGRAM: _____

DEMOGRAPHIC INFORMATION

Name: (First) _____ (Middle) _____ (Last) _____
Race/Ethnicity: African America/Black ☐ Caucasian/White ☐ Hispanic ☐ Native American ☐
Asian/Pacific Islander ☐ Other_____

County of Residence: _____ Highest Level of Education: _____

PHONE: (Home) _____ (Cell) _____ (Other) _____

Insurance Information: MEDICAID/MEDICARE (circle) POLICY NUMBER: _____
OTHER_____POLICY NUMBER:_____
SSI☐SSDI☐VA☐OTHER INCOME _____
Other Benefits and Services _____

MARITAL STATUS: Single: ☐Married: ☐Separated: ☐Divorced: ☐Widowed: ☐Other: _____
Dependents: (Name) _____ (Gender) _____ AGE: _____
(Name)_____ (Gender) _____ AGE: _____
(Name)_____ (Gender) _____ AGE: _____

Current Living Situation: Alone: ☐W/Spouse: ☐W/Children: ☐W/Parents: ☐Group Home: ☐Other: _____

Employed: Yes ☐No ☐Where/How Long: _____

EMERGENCY CONTACT INFORMATION

NAME: _____ RELATIONSHIP TO APPLICANT_____
ADDRESS: _____
PHONE: (Home) _____ (Cell) _____ (Other) _____

REFERRAL SOURCE INFORMATION

Referral Source: _____
Case Manager/Clinician Name: _____ Phone Number: _____
E-Mail Address: _____ Referring Center: _____

Legal Involvement: Yes: ☐No: ☐Type of Court Order:_____
Contact: _____ Phone Number: _____
Other Agencies Currently Involved:_____
_____

PRESENTING SYMPTOMS AND RISK ASSESSMENT

FORM PS-8 Referral Form (DMH)

CHECK ALL THAT APPLY

- ☐ None
- ☐ Suicidal Ideation
- ☐ Suicidal Gestures/Attempt
- ☐ Homicidal Ideation
- ☐ Homicidal Gesture/Attempt
- ☐ Other Destructive Behavior
- ☐ Violent Threats or Behavior
- ☐ Agitation
- ☐ Change in Sleep Pattern
- ☐ Delusions
- ☐ Appetite Change
- ☐ Hallucinations
- ☐ Confusion
- ☐ Tearfulness
- ☐ Low Energy/Fatigue
- ☐ Hopelessness
- ☐ Affective Disturbance
- ☐ Dissociative Reaction
- ☐ Mood Disturbance
- ☐ Disorganized Thoughts
- ☐ Psychomotor Retardation
- ☐ Alcohol Abuse (Last Use:_____)
- ☐ Drug Abuse (Last Use:_____)
  (Substance/s:_____)
  (_____)
  Other_____

HISTORY OF VIOLENCE/SEXUAL INAPPROPRIATENESS: Yes ☐ No ☐ (If Yes, Please Explain)

PLEASE DESCRIBE ALL THAT APPLY _____

(Attach Additional Pages if Needed)

TREATMENT HISTORY (Include Inpatient, Outpatient, Mental Health, and Substance Abuse):

(Attach Additional Pages if Needed)

CURRENT MEDICATIONS (Name/Dosage/Frequency):

(Attach Additional Pages if Needed)

DIAGNOSES:

PLEASE ATTACH INDIVIDUALIZED PLAN OF CARE AND MOST RECENT 90 DAY SUMMARY.

Healthy Connections MEDICAID

Henry McMaster GOVERNOR
Joshua D. Baker DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

Rehabilitative Behavioral Health Services (RBHS) Referral Form

This form shall be completed only by state agencies and submitted to private RBHS providers in accordance with HIPAA regulations as it contains Protected Health Information (PHI) of Medicaid beneficiaries.

Referring State Agency	☐ Department of Social Services Region: ☐ Department of Mental Health CMHC: ☐ Continuum of Care Region: ☐ Department of Alcohol and Other Drug Abuse Services Commission:	☐ Department of Disabilities and Special Needs Region: ☐ Department of Juvenile Justice Region: ☐ Department of Education District:

Provider (Referred to)				**NPI**	
Address					
City		**State**		**Zip**	
Phone Number		**Fax Number**			

Beneficiary Name					
Legally Responsible Person(s)					
Address					
City		**State**		**Zip**	
Date of Birth		**Gender**	☐ Female	☐ Male	
Social Security Number (last 4 digits)		**Medicaid Number**			

Medical Necessity	
Diagnosis – Code / Description	/
Diagnosis – Code / Description	/
Diagnosis – Code / Description	/
Clinical Rationale for Rehabilitative Behavioral Health Services Recommendations	

I recommend that the above-named Medicaid beneficiary receive Rehabilitative Behavioral Health Services. This beneficiary meets the Medical Necessity criteria for services as evidenced by a mental health and/or substance use disorder from the current edition of the DSM or the ICD.

Name of LPHA: _____ Credentials: _____

Signature of LPHA: _____ Date: _____

Recommendations for Rehabilitative Behavioral Health Services							
	Service Description	Procedure Code	Unit	Total Units Authorized	Start Date	End Date	Specific Frequency (# of units per day, # of days per week)
SCREENING AND ASSESSMENT SERVICES							
☐	Behavioral Health Screening	H0002	15 minutes				
☐	Psychiatric Diagnostic Assessment without Medical Services - Initial	90791	Encounter				
☐	Psychiatric Diagnostic Assessment with Medical Services – Initial	90792	Encounter				
☐	Mental Health Comprehensive Diagnostic Assessment – Follow–up	H0031	Encounter				
☐	Psychological Testing / Evaluation	96101	60 minutes				
☐	Comprehensive Evaluation – Initial	H2000	Encounter (average of 3 hours)				
☐	Comprehensive Evaluation – Follow up	H0031	Encounter				
SERVICE PLAN DEVELOPMENT							
☐	Mental Health Service Plan Development (Non-physician)	H0032	15 minutes				
☐	Service Plan Development (Team Conference w/ Client/Family)	99366	Encounter (minimum 30 minutes)				
☐	Service Plan Development (Team Conference w/o Client/Family)	99367	Encounter (minimum 30 minutes)				
CORE TREATMENT – PSYCHOTHERAPY AND COUNSELING SERVICES							
☐	Individual Psychotherapy	90832	30 minutes				
☐	Individual Psychotherapy	90834	45 minutes				

Recommendations for Rehabilitative Behavioral Health Services							
	Service Description	Procedure Code	Unit	Total Units Authorized	Start Date	End Date	Specific Frequency (# of units per day, # of days per week)
☐	Individual Psychotherapy	90837	60+ minutes				
☐	Group Psychotherapy	90853	60+ minutes				
☐	Family Psychotherapy w/o Client	90846	60+ minutes				
☐	Family Psychotherapy w/ Client	90847	60+ minutes				
☐	Multiple Family Group Psychotherapy	90849	60+ minutes				
☐	Crisis Management	H2011	15 minutes				
☐	Medication Management	H0034	15 minutes				
COMMUNITY SUPPORT SERVICES							
☐	Psychosocial Rehabilitation Service (PRS)	H2017	15 minutes				
☐	Behavior Modification (B-Mod)	H2014	15 minutes				
☐	Family Support (FS)	S9482	15 minutes				
☐	Therapeutic Child Care	H2037	15 minutes				
☐	Community Integration Services	H2030	15 minutes				

Note: Prior authorized periods of time for Community Support Services are as follows:

- Beneficiaries ages 0 to 21: Up to 90 days
- Beneficiaries age 22 and older: Up to 180 days

State Agency Representative Authorization (optional, per internal state agency processes)

Name: _____

Phone: _____

Title: _____

Signature: _____ Date: _____