BLAIR DRUG AND ALCOHOL PARTNERSHIPS DRUG AND ALCOHOL RC/ICM CASE MANAGEMENT REFERRAL FORM

RC/ICM services assist eligible persons in gaining access to the non-treatment resources that they need. RC/ICM services are provided to eligible individuals at no cost. Refusal to participate **will not** jeopardize your drug and alcohol treatment.

If you are interested, a case manager will contact you to set up an initial meeting. If you are in partial, intensive outpatient or outpatient, the contact will occur within seven days. If you are discharged from a detox or inpatient facility, the contact will occur within five days.

____ I am willing to meet with the case manager ____ I am not interested in this service at this time

_____ _____

Individual: Signature / DATE WITNESS: Please Print Name / DATE

Person/Agency making referral: _____

Client Name: _____ D.O.B: _____

Address: _____ Age: _____

_____ MA ID#: _____

Phone: _____ SS#: _____

Other Involved Agencies: _____

Is the client currently pregnant?	Yes ☐ No ☐
Does the client have children in their custody?	Yes ☐ No ☐
Is the client an IDU?	Yes ☐ No ☐
Is the client a survivor of overdose? If yes, date of overdose:	Yes ☐ No ☐
Is client currently incarcerated? If yes, scheduled release date:	Yes ☐ No ☐
Is client currently in an inpatient facility (drug and alcohol or mental health)? If yes, scheduled date of discharge:	Yes ☐ No ☐
Is the client a veteran?	Yes ☐ No ☐

Diagnosis

Axis I: _____ **Axis II:** _____

Additional Comments: _____

_____

Office Use Only:

Date Assigned: _____ Case Manager: _____

Date Opened: _____

Blair County Drug and Alcohol Program: Non-Treatment Needs Initial Screening Form

Client Name _____ SSN _____ Date _____

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The purpose of this section is to determine the need for a referral for non treatment needs at time of assessment. The individual may be offered a referral for case management services through Blair County Drug and Alcohol Program (BDAP).

DOMAINS	**Is the individual in need of assistance in the following areas? Check all that apply and add additional items:**	**If any areas are noted, check box**
EDUCATION/ VOCATION	☐ Interested in GED ☐ Interested in attending college ☐ Need OVR referral ☐ Interested in receiving tutoring	☐
EMPLOYMENT	☐ Interested in help with job search ☐ Need help with interviewing skills ☐ Need help with resume building ☐ Need help with job training	☐
PHYSICAL HEALTH	☐ Need referral to physician ☐ Need referral for eye/vision/dental care ☐ Interested in pregnancy testing ☐ Help finding support groups ☐ Need prenatal care ☐ Need assistance with medication management ☐ Interested in TB/HIV/AIDS/Hepatitis testing	☐
EMOTIONAL/MENTAL HEALTH	☐ Interested in MH counseling referral ☐ Need referral for psychotropic medication management	☐
FAMILY/SOCIAL	☐ Interested in family counseling referral ☐ Need childcare referral ☐ Interested in self-help groups (family/social) ☐ Need to improve social skills☐ Divorce/custody/child support/visitation assistance needed ☐ Need help developing healthy leisure activities ☐ Needs help filing a PFA	☐
LIVING ARRANGEMENT / HOUSING	☐ Rent is past due/eviction notice ☐ Need healthy recovery environment ☐ Living situation is unstable ☐ Need furniture ☐ Need referral to various housing agencies ☐ Need Section 8 application	☐
LEGAL STATUS	☐ Pending criminal charges ☐ Need referral for legal assistance ☐ Need assistance communicating with probation/ parole officer ☐ Facing collections/bankruptcy	☐
BASIC NEEDS (food, clothing, utilities)	☐ Need help obtaining clothing ☐ Need food/food stamps ☐ Need transportation/driver's license ☐ Need utility assistance ☐ Need Medical Assistance or health insurance	☐
LIFE SKILLS	☐ Referral for nutrition/healthy eating ☐ Parenting classes ☐ Need help establishing a budget/paying bills ☐ Need assistance with cooking, cleaning, grocery shopping, etc.	☐
GAMBLING	☐ Need help with compulsive gambling ☐ Interested in gambling support	☐
OTHER	Note:	
DOMAINS: _____/10	**REFERRED FOR CASE MANAGEMENT SERVICES TO BDAP: _____YES_____NO**	

If the client was not referred for case management services, how will identified needs be addressed?

DAP Note:

Client signature _____**Assessment Staff signature** _____DATE_____

Date _____**Assessment Staff (print name)** _____

Please fax to **Blair Drug and Alcohol Partnerships** at (814) 381-0922 Questions? Please call (814) 381-0921 Attachment 05Cb: rev 7-2020