



## 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 <input type="checkbox"/> No <input type="checkbox"/>
Does the client have children in their custody?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the client an IDU?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the client a survivor of overdose?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, date of overdose:	
Is client currently incarcerated?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, scheduled release date:	
Is client currently in an inpatient facility (drug and alcohol or mental health)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, scheduled date of discharge:	
Is the client a veteran?	Yes <input type="checkbox"/> No <input type="checkbox"/>

**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. If there are three or more domains identified, the individual may be offered a referral for case management services through Blair County Drug and Alcohol Program (BDAP). If the individual does not have three or more domains identified or refuses a referral to BDAP the assessor must document how non treatment needs are going to be addressed.

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	<input type="checkbox"/> Interested in GED <input type="checkbox"/> Need OVR referral <input type="checkbox"/> Interested in attending college <input type="checkbox"/> Interested in receiving tutoring	<input type="checkbox"/>
EMPLOYMENT	<input type="checkbox"/> Interested in help with job search <input type="checkbox"/> Need help with resume building <input type="checkbox"/> Need help with interviewing skills <input type="checkbox"/> Need help with job training	<input type="checkbox"/>
PHYSICAL HEALTH	<input type="checkbox"/> Need referral to physician <input type="checkbox"/> Interested in pregnancy testing <input type="checkbox"/> Need prenatal care <input type="checkbox"/> Interested in TB/HIV/AIDS/Hepatitis testing <input type="checkbox"/> Need referral for eye/vision/dental care <input type="checkbox"/> Help finding support groups <input type="checkbox"/> Need assistance with medication management	<input type="checkbox"/>
EMOTIONAL/MENTAL HEALTH	<input type="checkbox"/> Interested in MH counseling referral <input type="checkbox"/> Need referral for psychotropic medication management	<input type="checkbox"/>
FAMILY/SOCIAL	<input type="checkbox"/> Interested in family counseling referral <input type="checkbox"/> Interested in self-help groups (family/social) Divorce/custody/child support/visitation assistance needed <input type="checkbox"/> Need help developing healthy leisure activities <input type="checkbox"/> Need childcare referral <input type="checkbox"/> Need to improve social skills <input type="checkbox"/> Needs help filing a PFA	<input type="checkbox"/>
LIVING ARRANGEMENT / HOUSING	<input type="checkbox"/> Rent is past due/eviction notice <input type="checkbox"/> Living situation is unstable <input type="checkbox"/> Need referral to various housing agencies <input type="checkbox"/> Need healthy recovery environment <input type="checkbox"/> Need furniture <input type="checkbox"/> Need Section 8 application	<input type="checkbox"/>
LEGAL STATUS	<input type="checkbox"/> Pending criminal charges <input type="checkbox"/> Need assistance communicating with probation/ parole officer <input type="checkbox"/> Facing collections/bankruptcy <input type="checkbox"/> Need referral for legal assistance	<input type="checkbox"/>
BASIC NEEDS (food, clothing, utilities)	<input type="checkbox"/> Need help obtaining clothing <input type="checkbox"/> Need transportation/driver's license <input type="checkbox"/> Need Medical Assistance or health insurance <input type="checkbox"/> Need food/food stamps <input type="checkbox"/> Need utility assistance	<input type="checkbox"/>
LIFE SKILLS	<input type="checkbox"/> Referral for nutrition/healthy eating <input type="checkbox"/> Need help establishing a budget/paying bills <input type="checkbox"/> Need assistance with cooking, cleaning, grocery shopping, etc. <input type="checkbox"/> Parenting classes	<input type="checkbox"/>
GAMBLING	<input type="checkbox"/> Need help with compulsive gambling <input type="checkbox"/> Interested in gambling support	<input type="checkbox"/>
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) \_\_\_\_\_