Application for Adult Mental Health Case Management & Community Support Services

HUMANIM
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Behavioral Health Department

Instructions

Targeted case management services are available to assist adults with gaining access to the full range of mental health services, as well as to any needed medical, social, financial, counseling, educational, housing, and other supportive services needed to maintain stability in the community. Adults must meet the State of Maryland's medical necessity criteria for targeted case management services. Adults with Medical Assistance (MA) and adults who are dually eligible for Medicare/Medical Assistance are eligible for targeted case management. The Public Behavioral Health System reimburses targeted case management services rendered to those adults who meet the criteria for Uninsured Eligibility through the assistance/oversight of the Behavioral Health Administration.

- The mental health professional and/or mental health provider who works most closely with the applicant may assist the applicant in completing the attached forms.
- The Authorization of Disclosure for Case Management Services can be signed by the applicant (if the applicant is agreeable with having the services). If the applicant is not agreeable with having the services, the referral source can send the application.
- Medical Necessity Criteria must indicate why the applicant meets the stated criteria.
- Eligibility and need will be reviewed and determined by Humanim Case Management Program Director.
- **Applications can be faxed to Behavioral Health Admin at 410-381-5317, emailed to BHAdmin@humanim.org, or mailed to 6355 Woodside Ct., Columbia, MD 21046.**

Individual's Name: (Last) (First) (Middle)			
Individual's Address:			
Home #:	**Mobile #:**	**Email:**	
Sex: ☐ Female ☐ Male ☐ Transgender	**Primary Language:**	**Interpreter Needed** ☐ Yes ☐ No	
Race:	☐ **Hispanic/Latino** ☐ **US Citizen** ☐ **Legal Resident**	**Veteran:** ☐ Yes ☐ No	
DOB:	**Age:**	**Social Security #:**	**Marital Status:**
Highest Level of School Completed: ☐ 1-5 ☐ 6-12 ☐ H.S. Grad. ☐ Some College ☐ College Grad. ☐ Post-Graduate ☐ Other: _ _____			
Employment Status: ☐ Full-time ☐ Part-time ☐ None			

In order to qualify for services the individual must have a mental health DSM 5 diagnosis.

Primary Behavioral Health Diagnosis:	
ICD-10	DSM 5 Diagnosis
If the individual has a co-occurring Substance Use Disorder (cannot be primary diagnosis)	
ICD-10	DSM 5 Diagnosis

Social Elements Impacting Diagnosis (Check all that apply):			
☐ None	☐ Access to Health Care	☐ Housing Problems	☐ Social Environment
☐ Educational	☐ Legal System/Crime	☐ Occupational	☐ Homelessness
☐ Financial	☐ Primary Support	☐ Other Psychosocial/Enviro.	☐ Unknown

Medical Necessity Criteria for Admission (at least one item must be selected)		**State reason(s) for selection:**
☐	The applicant is at risk of or needs continued treatment to prevent inpatient psychiatric treatment.	
☐	The applicant is at risk of or needs community treatment to prevent being homeless.	
☐	The applicant is at risk of incarceration or will released from a detention center or prison.	
☐	The applicant is a participant in the Continuum of Care Program (formerly known as "Shelter Plus Care").	***HUD requires an individual who receives rental assistance via the Continuum of Care Program must receive case management services as long as rental assistance is provided to the individual.***

The specific diagnostic criteria can be waived for the following two conditions:	
☐	A participant committed as not criminally responsible who is conditionally released from a BHA facility, according to the provisions of health General Article, Title 12, Annotated Code of Maryland.
☐	A participant in a BHA facility or a BHA-funded inpatient psychiatric hospital that requires community services. This excludes participants eligible for DDA's residential services.

Current Substance Use			
Type of Drug (Including Alcohol)	Date(s) Used	Amount	How Used (Smoked, IV, etc.)

Previous History of Substance Use			
Type of Drug (Including Alcohol)	Date(s) Used	Amount	How Used (Smoked, IV, etc.)

List current or last known psychiatric hospitalization:	
Name of Hospital/Facility	Date of Admission/Discharge

Medical Diagnoses (If applicable):	

Current Psychotropic Medications:		
Name of Medication	Dosage	Frequency

Legal:
Has the applicant ever been arrested: ☐ Yes ☐ No
If yes, is the applicant currently on parole/probation: ☐ Yes ☐ No
Probation Agent's name:
Probation Agent's phone #:
Current charge(s):
Is the applicant currently on a Conditional Release Order: ☐ Yes ☐ No
CFAP Monitor's name:
CFAP Monitor's phone #:

Current Providers and Supports: (or most recent if not currently in treatment)

Name/Title:	Agency/Program	Contact Information:
Psychiatrist/Prescriber:		Telephone #: Fax #: Email:
Therapist/Clinician: Needs one		Telephone #: Fax #: Email:
Other Providers (Mobile Treatment\ACT, PRP, Supported Living, SEP, etc.)		Telephone #: Fax #: Email:
Substance Use Treatment Provider:		Telephone #: Fax #: Email:
Primary Care Physician:	**Address:**	Telephone #: Fax #: Email:
Emergency Contact:	**Relationship to applicant:**	Telephone #: Fax #: Email:

Current Income and Entitlements: If applicant has no income, check here: ☐

Type of Income	Amount (Monthly)	Status
Supplemental Security Income (SSI)	**$**	☐ Active ☐ Inactive ☐ Pending
Social Security Disability Insurance (SSDI)	**$**	☐ Active ☐ Inactive ☐ Pending
Temporary Disability Allowance Program (TDAP)	**$**	☐ Active ☐ Inactive ☐ Pending
Veteran's Benefit (VA)	**$**	☐ Active ☐ Inactive ☐ Pending
Employment Earnings	**$**	# of Hours Worked 40
Other Income: (Specify):	**$**	☐ Active ☐ Inactive ☐ Pending

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Type of Insurance	Insurance/Policy #	Status
Medical Assistance (MA)	#	☐ Active ☐ Inactive ☐ Pending
Medicare (MC)	#	☐ Active ☐ Inactive ☐ Pending
If NO insurance, please check: ☐		Does individual meet the criteria for **Uninsured Eligibility**? ☐ Yes ☐ No ☐ Unknown

Any additional information that you feel would be helpful in serving this individual:

Who is making this referral: ☐ Self ☐ Family ☐ Case Manager ☐ Other:

Contact Information of the person making referral (if not self):

Name: **Agency:**

Phone: **Fax:** **E-mail:**

Referring Individual's Signature: _____

******DO NOT WRITE BELOW THIS LINE. HUMANIM USE ONLY******

Level I-General: Based on the severity of the participant's mental illness and if participant meets at least one of the following criteria

☐ Not linked to mental health and medical services
☐ Transitioning from one level of care to another
☐ Urgent If yes, describe:
☐ Lacks basic supports for shelter, food, and income
☐ Needs to maintain community-based treatment and services

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Level II- Intensive: Based on the severity of the participant's mental illness and if participant *urgently* meets more than one

☐ Not linked to mental health and medical services
☐ Transitioning from one level of care to another
☐ Urgent If yes, describe:
☐ Lacks basic supports for shelter, food, and income
☐ Needs to maintain community-based treatment and services

Consent for Disclosure for Adult Case Management Services

I, _____, give my consent for the release of the following written information from _____ to the Humanim, Inc. (case management provider) for the purpose of determining eligibility for targeted case management services.

- ☐ Psychosocial assessment
- ☐ Psychiatric evaluation
- ☐ Psychological testing (if applicable)
- ☐ Physical\Health history
- ☐ Discharge Summary
- ☐ Income\Insurance
- ☐ Substance Use history
- ☐ Legal history
- ☐ Individual Treatment or Rehabilitation Plan
- ☐ Admission Summary
- ☐ Current or previous medications
- ☐ Other: _____

Prohibition of Re-Disclosure: This information has been disclosed to Humanim, Inc. (case management provider) from your records whose confidentiality is protected. Any further disclosure is prohibited. This disclosure of information is effective until ____ / ____ / ____ (12 months from the date of your signature).

Applicant's Signature: _____ Date: ____ / ____ / ____

Witness's Signature: _____ Date: ____ / ____ / ____

Legal Guardian's Signature: _____ Date: ____ / ____ / ____
(If applicable)

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