The Mental Health Center of Greater Manchester

MHCGM Care Transitions Team Referral Form

Fax completed Referral form and a Release of Information to Katelyn Griggs, Administrative Assistant, at 603.628.7782.
Office phone contact 603-606-8084

Referral source information

*Referral date:*_____ *Referral source name and credentials:* _____

*Referral source phone number:*_____ *Referral source organization:* _____

Client information

Client name: _____ *DOB:* _____ *Social Security #:* _____

*Address:*_____ *Phone number:* _____

Anticipated transition date: _____ Additional Notes: _____

Gender (please circle one): Male Female Transgender No Answer

☐ Non-Hispanic ☐ White ☐ African American ☐ Asian-American ☐ Native-American ☐ Other

Insurance: NONE ☐ or Medicaid ☐

If YES, Type: (ie: spend-down, NHHF, Wellsense) _____

If NONE, Medicaid application completed? Yes or No Filed? Yes or No (please circle)

Is client receiving SSI or SSDI? ☐ Yes ☐ No If No, has SSI/SSDI application completed? Yes or No (please circle)

Referral *was discussed* with client and the client is volunteering to participate? YES or NO

Current areas of need:

☐ Housing ☐ Benefits ☐ MH/SA treatment ☐ Money mgmt. ☐ ADL skills ☐ Family support

_____

_____

_____

_____

Client eligibility:

☐ Client has a mental health diagnosis or evidence of a psychiatric disorder with significant impairments in functioning

☐ Has Medicaid or is Medicaid Eligible

Must meet at least three or more of the following:

☐ At risk of homelessness/unstable housing
☐ Inability to perform daily living activities
☐ Substance use with negative impact
☐ Lack of basic subsistence needs (food stamps, benefits, medical care, transportation)
☐ Suicide risk
☐ Lack of positive social/natural supports
☐ Inability to manage money
☐ Employment challenges

AND the following

☐ Client is a resident of one of the following cities/areas:

- ☐ Greater Manchester
- ☐ Greater Derry
- ☐ Greater Salem
- ☐ Town: _____

☐ Client is experiencing a *critical transition* (defined by *at least one* of the following):

- ☐ Discharge from inpatient setting (psychiatric or medical)
- ☐ Community reintegration (discharge from Hillsborough County HOC or Rockingham County HOC)
- ☐ Youth, transitioning from children's behavioral health system to adult.

☐ Client is ineligible for, or unable to access other enhanced treatments.

☐ Client has clear need for outreach efforts due to difficulty engaging in treatment and services due to psychiatric symptoms or problematic life circumstances.

The Mental Health Center of Greater Manchester

Client Referral Information

Reason for referral:

_____

_____

Client's current mental health provider: _____

Primary MH diagnosis and/or observations: _____

_____

Substance use:

_____

Physical health issues:

_____

_____

Medications, psychiatric and/or medical:

_____

_____

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CTI team notes (for internal use only):

Pre-screening date:_____Screening Complete Date:_____Eligible: YES or NO

Any questions regarding this referral please call us at 603-606-8084.

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NETWORK 4 HEALTH