Bridges Clubhouse
Case Manager Client Referral Check List

Client Name: ______________________________

Client Phone Number: ______________________________

Case Manager Name: ______________________________

Case Manager Phone Number: ______________________________

In order to expedite your clients' intake process at Bridges Clubhouse,

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

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 ____

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(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):

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____

____

____

____

(Attach Additional Pages if Needed)

DIAGNOSES:

____

____

____

____

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

Healthy Connections MEDICAID

Henry McMaster GOVERNOR
Deirdra T. Singleton ACTING 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: _____________