Central Community Health Board, Inc. (CCHB)- Housing Referral Form
Mental Health Plan of Care (MHPC)

(Revised 10/4/2016)

Date Completed: ___/___/___ **Received by MHAP: ___/___/___**

Mental Health Agency: _____ **Case Manager: _____**
Telephone #: _____ **Fax #: _____**

(List both code & description)

DSM IV Axis: ( ) Primary: ____.___ _____
Axis: ( ) Secondary: ____.___ _____

Demographic Information

Consumer Name: _____, _____ _____
(Last Name) (First Name) (M I)

Current Address (Last Known): _____ _____ ___ _____
(Street) (City) (State) (Zip)

Telephone Number: (_____) _____ **County of Residence: _____**

Social Security Number: _____ ___ _____ **Date of Birth: ___/___/___** **Male__ Female __**

Race: _____ **Marital Status: _____** **Veteran? Yes ___ No ___**

Monthly Income: $_____.___ **Source of Income: _____**
Other Benefits: (check all that apply)

Medicare___ **Residential State Supplement (RSS) ____**

Medicaid ___ **Spend Down? ___ Yes ___ No** **Amount $_____**

Disability Assistance (D. A.) ___ Yes ___ No **Amount $ _____**

Child Support ___ Amount $_____ **Food Stamps ___** **Amount $_____**

Payee: _____ Telephone Number: (_____) _____
(Name)

Mailing Address: _____ _____ ____ _____
(Street) (City) (State) (Zip)

Advance Directives: Living Will? ___Yes __No Health Care Power of Attorney __ Yes ___ No

Guardian: _____ Telephone Number: (_____) _____

Mailing Address: _____ _____ ____ _____
(Street) (City) (State) (Zip)

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List all known hospitalizations and/or treatment services:

Hospital/Program	Begin Date	End Date	Reason for Leaving
_____	___/___/___	___/___/___	_____
_____	___/___/___	___/___/___	_____
_____	___/___/___	___/___/___	_____
_____	___/___/___	___/___/___	_____

Briefly describe the consumer's mental health symptoms including signs of decompensation: _____
_____
_____

List history of previous/current criminal history: _____
_____
_____
_____

Is there any potential for violence? Yes____ No _____ if yes, please explain and list history of violence if applicable: _____
_____
_____
_____
_____
_____

Is there any substance use? Yes ____ No ____ if yes, please list substance(s) of choice: ___
_____
_____

Please describe history of substance use and periods of sobriety if applicable: _____
_____
_____
_____

Has the consumer been involved in any treatment programs for the substance use? Yes __ No___
If yes, please explain and list dates if applicable: _____
_____
_____

Is the consumer involved in any current Developmental Disability Services? Yes __ No __
If yes, please provide the case worker's name and telephone number: _____
_____

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Does the consumer have any significant needs? Check all that apply:

Ambulatory problems ___	**Hypertension ___**	**Dental Problems ___**
Hearing Impairment ___	**Asthma ___**	**Allergies ___**
Diabetes ___	**Eating Disorder ___**	**Incontinence ___**
Visual Impairment ___	**Heavy Smoker ___**	**Sleeping Disorder ___**
Epilepsy ___	**Unable to Read ___**	**Other: _____**

Briefly describe needs that are checked: _____
_____
_____
_____
_____

Describe techniques that have been effective in working through problem areas or service needs:
_____
_____
_____

Describe techniques that have not been effective: _____
_____
_____
_____
_____

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Authorization for Release of Information or Request for Information

Note: This information has been disclosed to you or is being requested from records protected by the Federal confidentiality rules (42 CFR Part 2), Ohio law and HIPAA. Under Ohio law, this

information may not be re-released without the written authorization of the individual, except as allowed or required by law. The Federal rules prohibit making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by (42 CFR Part 2), Ohio law or HIPAA, whichever is more restrictive. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or organization to receive may be re-disclosed and no longer protected by federal privacy regulations.

1). Name of Patient: _____
Date of Birth: ___/___/___ Social Security Number: _____-___-_____
Address: _____
City, State and Zip Code: _____
Telephone Number: _____- _____

2). Purpose of Disclosure or Request for Information: _____
_____

3). Specific information to be disclosed or requested - **Patient must initial each category**:

_____ DAF
_____ Doctor's Notes
_____ Treatment History/Plan
_____ Alcohol & Drug Treatment
_____ Medication History
_____ Psychiatric Evaluation
_____ Community Support Records
_____ Other (Specify) _____

4). Check if information is to be disclosed by CCHB ____.
The information is to be disclosed by: _____

If not CCHB, please fill in the following information:
Name and address of the person/organization authorized to use, disclose or release the information: _____
_____

5). Check if information is to be received by Central Community Health Board (CCHB) ___

_____ __/__/__ _____ __/__/__
Consumer Signature Date Referring Agent/Witness Signature Date

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Consumer's Comments: _____
_____
_____
_____

Home Administrator's Comments: _____

_____
_____
_____

_____ ____/____/____
Consumer's Signature Date

_____ ____/____/____
Home Administrator's Signature Date

_____ ____/____/____
Case Manager's Signature Date

****

Emergency Fact Card

Consumer's Name: _____ Date of Admission: ___/___/___

Date of Birth: ____/____/____ Social Security Number: _____-____-_____

Medicaid#: _____ Medicare #: _____ Private Insurance: _____

In Case of Emergency Contact: Family/Other: _____

Telephone #: _____-_____ Address: _____

Case Manager: _____ Telephone #: ___-_____ Address: _____

Medical Provider: _____ Telephone #: ___-_____ Address: _____

Psychiatrist/Agency:_____

Telephone #: ____-_____ Address: _____