CLEAR

The Department of Medical Assistance Services
Community Stabilization (S9482) Referral Form

MEMBER INFORMATION			
Member First Name:		**Member Last Name:**	
Medicaid #:		**Member Date of Birth:**	
Member Plan ID #:		**Gender:**	
Member Address:			
City, State, ZIP:			
Member Phone #:			
Parent/Guardian Name (if applicable):		**Parent/Guardian Phone # (if applicable):**	

REFERRING PROVIDER INFORMATION		COMMUNITY STABILIZATION PROVIDER	
Organization Name:		**Organization Name:**	Born To Be Great II
Provider Phone #:		**Provider Phone #:**	(804) 340-6585
Provider E-Mail:		**Provider E-Mail:**	recovery@born2bgreat.org
Provider Address:		**Provider Address:**	2114 Dabney Rd. Suite B
City, State, ZIP:		**City, State, ZIP:**	Richmond, VA 23230
Provider Fax #:		**Provider Fax #:**	(804) 447-9304
Clinical Contact Name & Credentials:		**Clinical Contact Name & Credentials:**	
Clinical Contact Phone #:		**Clinical Contact Phone #:**	

REASON FOR REFERRAL
Date of Discharge/anticipated discharge:_____

By my signature (below), I am attesting that 1) I have performed care coordination activities and collaborated with the Community Stabilization provider as part of my discharge planning 2) the member is in need of Community Stabilization Services as part of a comprehensive discharge plan.

Signature (actual or electronic) referring provider:_____

Printed Name of referring provider: _____

Title: _____

Credentials (if applicable):_____

Date: _____

BORN2BGREAT
GET RECOVERY & EXPECT GREATNESS
2114 Dabney Rd. Ste. B
Richmond, VA 23230
O:(804) 340-6585
F: (804) 447-9304
www.Born2BGreat.org

Initial Screening Form

Hi! Would you mind taking 10 minutes to complete this form? All fields are required unless otherwise noted. Please write "N/A" if the field does not apply.

1. Full Name: _____

2. Date of Birth: _____ EX. (MM/DD/YYYY)

3. Home Address:

_____

House Number **Street** **City** **State** **Zip**

(If Homeless write "Displaced" or Homeless)

4. Phone Number: _____

5. Email Address: _____

6. Gender:

○ Male ○ Female ○ Transgender ○ Other_____

7. Race:

○ Asian ○ Black or African American ○ Hispanic or Latino ○ Multiracial, non-hispanic

○ Native Hawaiian or Other Pacific Islander ○ White ○ Other

8. Managed Care Organization (Medicaid Insurance Provider):

○ Optima ○ Molina ○ Magellan ○ Sentara ○ Aetna

○ *Anthem* ○ United Healthcare ○ Other

We are currently NOT an approved provider for Anthem Medicaid Member.

9. Medicaid ID Number: _____(If unknown Please write Social Security Number.)

10. My major goal for treatment is:

_____

_____

_____

_____

_____

11. Drug of Choice (check all that apply):

□ Alcohol □ Benzodiazepines □ Cannabis □ Cocaine, Crack

□ Methamphetamines, MDMA □ Opioid pills, Heroin, Fentanyl

12. When did your use become unmanageable? (MM/DD/YYYY): _____

13. Date of last use? (MM/DD/YYYY): _____

14. I am on medication assisted treatment. I take (check all that apply):

□ Acamprosate □ Bromocriptine □ Buprenorphine □ Gabapentin

□ Methadone □ Naltrexone □ Sublocade □ Suboxone

□ Topiramate □ Vivitrol □ None of the above □ Other

15. Have you noticed that you may have… (check all that apply):

□ Taken the substance in larger amounts or for longer than you're meant to

□ Wanted to cut down or stop using the substance but not managing to

□ Spent a lot of time getting, using, or recovering from use of the substance

□ Cravings and urges to use the substance

□ Not managing to do what you should at work, home, or school because of substance use

□ Continued to use, even when it causes problems in relationships

□ Given up important social, occupational, or recreational activities because of substance use

□ Used substances again and again, even when it puts you in danger

□ Continued to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance

□ Needed more of the substance to get the effect you want (tolerance)

□ Developed withdrawal symptoms, which can be relieved by taking more of the substance

16. Within the last 12 months, which services have you utilized (check all that apply):

□ Hospitalization □ Crisis Stabilization □ Residential Substance Abuse Treatment (Inpatient)

□ Outpatient Substance Abuse Treatment □ Mental Health Skill Building □ Substance Abuse Case Management

If you answered yes to any of the above, when were you discharged or when will you be discharged and from what program ?

_____

_____

_____

18. Mental Health Diagnosis (check all that apply):

□ Anxiety □ Bipolar Disorder □ Borderline Personality Disorder □ Current Suicidal or Homicidal Ideation

□ Major Depression □ Panic Disorder □ Post-Traumatic Stress Disorder □ Schizophrenia

□ No Previous Mental Health Diagnosis □ Other

19. Do you feel your mental health is declining? ○ Yes ○ No

20. Have you had difficulty with treatment because of feelings, behaviors, or circumstances? ○ Yes ○ No

21. Is your current environment supportive of recovery? ○ Yes ○ No

22. Medical Concerns (check all that apply):

□ Uncontrolled Seizure Disorder □ Uncontrolled Diabetes □ Uncontrolled Hypertension □ Impaired Mobility

□ Infectious diseases (HIV, HCV, HBV, TB, C-Diff) □ Oxygen dependent □ None of the above □ Other

23. Do you have a primary care provider or psychiatrist? If so, what is their name and phone number:

_____

_____

_____

_____

_____

24. Please list your current medications:

1._____ 11._____
2._____ 12._____
3._____ 13._____
4._____ 14._____
5_____ 15._____
6._____ 16._____
7._____ 17._____
8._____ 18._____
9._____ 19._____
10._____ 20._____

25. Are you prescribed benzodiazepines for long-term use? ○ Yes ○ No ○ Yes, I am on a taper plan

26. Do you have upcoming appointments or court dates? ○ Yes ○ No

28. Other areas I would like help with (check all that apply):

□ Education □ Family reunification □ Financial resources □ Identification □ Legal

□ Medical □ Occupational □ Support systems □ Stable housing

29. Please List One Emergency Contact:

Name:_____ **Relationship:**_____

Address:_____ **Phone Number:**_____

Disclaimer: The application is to determine eligibility and is not a guarantee of acceptance. Acceptance does not guarantee a bedspace. Bedspace is first come, first served. At this time, we are unable to hold bedspaces. Applicant must verify bedspace availability no later than 24 hours from the date of scheduled transition into the program. Intakes are by appointment only.

_____ _____

Applicant Signature Date of Application (MM/DD/YYYY)