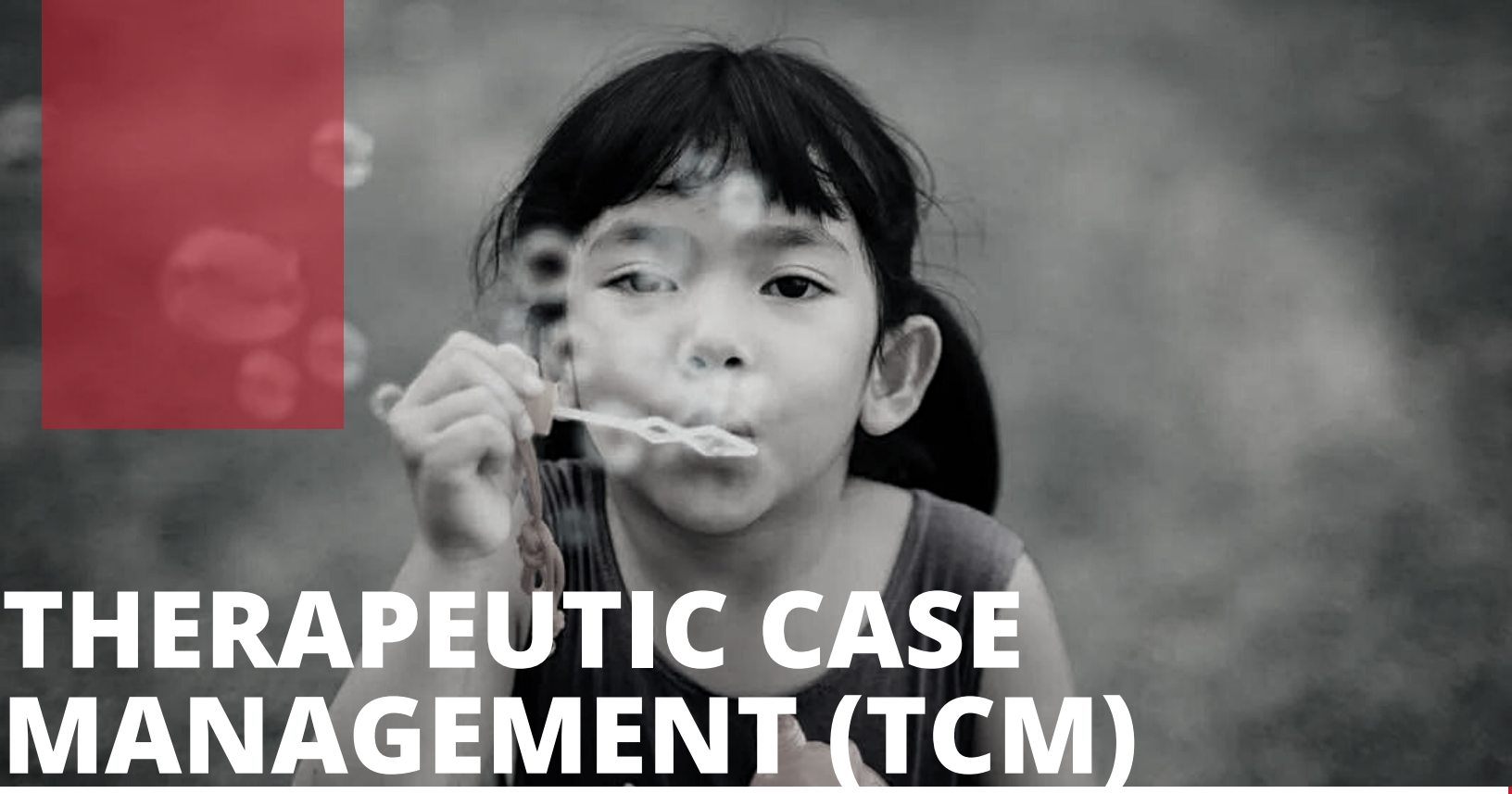

THERAPEUTIC CASE MANAGEMENT (TCM)

In partnership with Pierce County Behavioral Health, Seneca's innovative Therapeutic Case Management (TCM) program provides behavioral support and case management services to non-Medicaid eligible youth in Pierce County, not residing in Tacoma city limits. TCM participants include youth who do not qualify for Wraparound with Intensive Services (WISe), youth who may be stepping down from WISe, or youth who would benefit from additional behavioral support and case management services.

- Outpatient and School Based Mental Health Services.
- Includes individual and/or family therapy 1x per week.

- Wraparound with Intensive Services (WISe) addresses acute behavioral and mental health needs for youth and their families.

- TCM provides intensive behavioral and case management support to youth and families.
- Services can be provided in the community, in-home or in-school.

- Children's Long-term Inpatient Placement (CLIP) provides intensive psychiatric treatment to youth who do not meet the requirements for a lower level of care.

For more information or to submit a referral to TCM, contact us at:

TCMReferrals@senecacenter.org
or by phone at (253) 356-8459

www.senecafoa.org

Pierce County Human Services

SENECA FAMILY OF AGENCIES | UNCONDITIONAL CARE

SENECA
FAMILY OF AGENCIES | UNCONDITIONAL CARE

Therapeutic Case Management Referral Form

Call: 253-356-8459; Email: TCMreferrals@senecacenter.org
Or send via confidential fax: 510-830-3596

Date of Referral:	**Office Only**
Name of Referent:	INTAKE APPT DATE & TIME:
Referent Phone No.:	COUNSELOR ASSIGNED:
Referent Email:	SCHEDULED BY:
Relationship to Client:	SCHEDULED ON:

CLIENT INFORMATION

Name:	DOB:	Age:
Ethnicity:	Primary Language:	
Gender:	Pronouns:	
Child/Youth Primary Address:		
Child/Youth Phone:	Voicemails? Yes ☐ No ☐	
Primary Caregiver(s) Name/Relationship to Youth:		
Phone:	Voicemails? Yes ☐ No ☐	
Email:		
What school does the youth attend?		
Do you have primary insurance? Yes ☐ No ☐	Primary Insurance:	
Other Important Adults/Family Member(s)		
Name:	Relationship to Child/Youth:	
Name:	Relationship to Child/Youth:	

REASON FOR REFERRAL

Presenting Symptoms (please circle all that apply):

Suicidal Ideation ☐	Depressed Mood ☐	Tearful/Cries Often ☐	Hyperactive ☐
Suicide Attempt ☐	Social Withdrawal ☐	Easily Distracted ☐	Poor Impulse Control ☐
Physical Aggression ☐	Verbal Aggression ☐	Anxious ☐	Fidgety ☐
Paranoia ☐	Hypervigilant ☐	Obsessive Thoughts ☐	Compulsive Behavior ☐
Self-Mutilation ☐	Phobias ☐	Bedwetting ☐	Nightmares ☐
Hallucinations ☐	Disrupted Sleep ☐	Harmful to animals ☐	Drug Use ☐
Homicidal Ideation ☐	Weight loss/gain ☐	Poor social skills ☐	Disrupted Attachment ☐

Reasons for Referral:

What previous behavioral/ mental health services have been attemtped?

CONTACT (Check all that apply)

Best days to contact: M ☐ T ☐ W ☐ Th ☐ F ☐	Time of day: Mornings ☐ Afternoons ☐ Evening ☐

Pierce County HUMAN SERVICES