





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. 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.

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- 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 our main line 206-948-0096 or our toll-free line 833-522-0137.



Therapeutic Case Management Referral Form

Call our main line 206-948-0096 or toll-free line 833-522-0137;

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 <input type="checkbox"/> No <input type="checkbox"/>		
Primary Caregiver(s) Name/Relationship to Youth:			
Phone:	Voicemails? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Email:			
What school does the youth attend?			
Do you have primary insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> 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 attempted?			
CONTACT (Check all that apply)			
Best days to contact: M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F <input type="checkbox"/>		Time of day: Mornings <input type="checkbox"/> Afternoons <input type="checkbox"/> Evening <input type="checkbox"/>	

