|  |  |  |
| --- | --- | --- |
| LOC: Day Treatment: \_\_\_ Wrap: \_\_\_ ICC (Intensive Care Coordination): \_\_\_ IIBHT (Intensive In-Home Behavioral Health Treatment): \_\_\_ CATS (Crisis and Transition Services): \_\_\_ PCIT (Parent-Child Interaction Therapy): \_\_\_ | | |
| Date of Referral: |  | Release of Information signed? Please complete for follow up with referring agency/individual.  Yes \_\_\_\_ No \_\_\_\_\_ |
|  | |  |
| Name of Youth: | | Date of Birth: |
| Address: | | Age:  Grade: |
| City, State, Zip: | | Gender:  Pronouns: |
| Phone #: | | Email: |
| Ethnicity: \_\_\_Hispanic/Latinx \_\_\_Not Hispanic/Latinx \_\_\_ Decline to answer | | |
| Race: \_\_\_American Indian or Alaska Native \_\_\_Asian \_\_\_Black or African American  \_\_\_Native Hawaiian or Other Pacific Islander \_\_\_White \_\_\_Other \_\_\_Unknown \_\_\_Decline to Answer | | |
|  | |  |
| Parent/Guardian Name/s: | | |
| Address: | | |
| City, State, Zip: | | |
| Phone #: | | |
| Email: | | |
| Is legal guardian different than that listed above: No: \_\_\_\_\_ Yes:\_\_\_\_ (Please, provide information below) | | |
| Legal Guardian: | | Phone #: |
| Address: | | City, State, Zip: |
| Email: | |  |

**Family**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Age (if Youth) | | Relationship to youth? |
|  |  | |  |
|  |  | |  |
|  |  | |  |
|  |  | |  |
|  |  | |  |
|  |  | |  |
| Person Making Referral: | | Phone #: | |
| Referral Agency: | | Email: | |
| Please give a detailed description of the behaviors and concerns that prompted this referral (criminal history, school issues, family dynamics, current living situation, etc.):  Programs/Services that the youth/family have participated in or are currently participating in: | | | |

|  |  |  |
| --- | --- | --- |
| **Youth’s Name:** |  | **Comments** |
| Youth and family are engaged in Mental Health services through Center for Human Development |  |  |
| Youth is at risk of placement outside the home community due to mental health/behavioral challenges: risk of residential treatment, currently in residential treatment, or has regressed upon return from a treatment facility. |  |  |
| Youth was involved in Mental Health Crisis incident. |  | If yes, provide date: |
| **Additional Supporting Criteria (check all that apply)** | | |
| Youth has a family  ”Family” means the biological or legal parents, siblings, other relatives, foster parents, legal guardians, spouse, domestic partner, caregivers and other primary relations to the individual whether by blood, adoption, legal or social relationships. Family also means any natural, formal or informal support persons identified as important by the individual. |  |  |
| **Youth is involved with the following child serving systems/agencies:** | | |
| Child Welfare |  | Contact: |
| Juvenile Justice |  | Contact: |
| Union Co CARE |  | Contact: |
| School |  | Contact: |
| Developmental Disabilities Program |  | Contact: |
| Other |  | Contact: |
| Other |  | Contact: |
| Youth is displaying emotional and behavioral issues that result in social concerns |  |  |
| School disruption due to suspension and/or expulsion |  |  |
| Permanency status in question (disrupting adoption, pre-finalized adoptions, new relative placements, etc.) |  |  |
| Elevating risk of harm to self or others including sexualized behaviors, fire setting etc. |  |  |
| Youth has medical condition/s that may be impacting/ contributing to behavioral challenges. |  |  |
| Youth is struggling with substance use/electronic addiction/or other addictive behaviors. |  | Details: |
| Parent/Family is struggling to support youth’s behaviors in the home. |  |  |
| **Insurance Coverage/Funding:** | Yes | Group and ID Number/Details |
| EOCCO |  |  |
| OHP/Medicaid/Open Card |  |  |
| Private Insurance |  |  |
| Other |  |  |

**Referral Outcome**

|  |  |
| --- | --- |
| **Youth’s Name:** |  |
| **Family is accepted into Wrap:** | |
| Assigned to the following Wrap Care Coordinator: |  |
| **Family is accepted into ICC:** | |
| Assigned to the following Care Coordinator: |  |
| **Family is accepted into CATS:** | |
| Assigned to the following Team: |  |
| **Family is accepted into IIBHT:** | |
| Assigned to the following Team: |  |
| **Family is accepted into Day Treatment:** | |
| Assigned to the following Program: |  |
| **Family is accepted into PCIT:** | |
| Assigned to the following Therapist: |  |
| **Family is referred to Other:** | |
| Engagement was attempted but was not successful. Describe: | |
| Family declined to participate in services. Explain: | |
| Family is screened into alternate services.  Explain: | |

\* If ROI is in place, give copy of completed Outcome to referring agency/individual.

Return completed referral form to [youthprograms@chdinc.org](mailto:youthprograms@chdinc.org) via secure email or mail/drop off at CHD, Attn: Children’s Care Coordinator.