90-Day Assessment of Suitability of a Child for Residential Treatment

Revised: January 18, 2019

Child Information		
NAME:	**MEDICAID NUMBER:**	**SOCIAL SECURITY NUMBER:**
DATE OF BIRTH:	**GENDER:** ☐ Male ☐ Female	
COUNTY OF ORIGIN:	**CIRCUIT:**	**AREA:**
CURRENT MEDICATIONS:		
Single Point of Access (SPOA) Contact Information		
NAME:	**PHONE NUMBER:**	**FAX NUMBER:**
CURRENT MENTAL HEALTH ISSUES, TREATMENT PROGRESS		
DESIRED TREATMENT OUTCOME		
CURRENT DSM-5 DIAGNOSIS:		
Prescribing Physician		
NAME:	**PHONE NUMBER:**	

Child's Current Living Arrangement			
NAME OF CURRENT LOCATION/CAREGIVER:			
PLACEMENT TYPE: ☐ In-Patient ☐ STGH ☐ Shelter ☐ Detention Center ☐ CSU ☐ Foster Home ☐ Relative ☐ Other:			
DAYTIME PHONE NUMBER:	**EVENING PHONE NUMBER:**		
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**

Community Based Care Caseworker			
NAME:	**PHONE NUMBER:**	**EMAIL ADDRESS:**	
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**

Guardian ad litem		
NAME:		**EMAIL ADDRESS:**
PHONE NUMBER:	**FAX NUMBER:**	

Attorney Ad Litem		
NAME:		**EMAIL ADDRESS:**
PHONE NUMBER:	**FAX NUMBER:**	

Juvenile Justice Probation Officer	
NAME:	**EMAIL ADDRESS:**
PHONE NUMBER:	**CELL PHONE:**

We believe that _____, a child in the custody of the Department of Children and Families/CBC, is emotionally disturbed and may need residential treatment, pursuant to Section 39.407, Florida Statute.

I certify the referral form and package are complete and that all information will be provided to the Qualified Evaluator upon assignment.

SIGNATURE OF SPOA **DATE**

Note: Referral Cannot Be Processed if Information Submitted is Illegible or Incomplete.

Magellan of Florida
To transmit request information:
Fax: 1-888-656-6823
Phone: 1-800-562-4059