Reconsideration Referral Form

Child Information			
NAME:	MEDICAID NUMBER:		SOCIAL SECURITY NUMBER:
DATE OF BIRTH:	GENDER: ☐ Male ☐ Female		
COUNTY OF ORIGIN:	CIRCUIT:		AREA:
EVALUATOR:	DATE OF LAST SUITABILITY:	PRIOR RECOMMENDATION: ☐ In-Patient ☐ STGH ☐ Residential Not Recommended	

Single Point of Access (SPOA) Contact Information		
NAME:	PHONE NUMBER:	FAX NUMBER:

DSM-V	
DSM-5 DIAGNOSIS:	

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

Community Based Care Caseworker			
NAME:	PHONE NUMBER:	E-MAIL ADDRESS:	
ADDRESS:	CITY:	STATE:	ZIP:

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Guardian ad litem	
NAME:	**E-MAIL ADDRESS:**
PHONE NUMBER:	**FAX NUMBER:**

Attorney ad litem	
NAME:	**E-MAIL ADDRESS:**
PHONE NUMBER:	**FAX NUMBER:**

Updated Clinical Information: explanation of child's decompensation since the time of the last assessment (i.e., Baker Acts, self injurious behaviors, etc.)

Additional Comments or Information

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

SIGNATURE OF SPOA	**DATE**

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