Initial Suitability Assessment - Referral Form

Revised: October 16, 2019

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| Child Information |
| NAME:      | medicaid number:      | Social Security Number:      |
| Date of Birth:      | Gender:[ ]  Male [ ]  Female  |
| County of Origin:      | Circuit:      | Area:      |
| Current Medications:      |
| date of Multidisciplinary team (MDT) Meeting:      |
| Single Point of Access (SPOA) Contact Information |
| NAME:      | Phone number:      | EMAIL:      |
| Diagnosis |
| DSM-5: |  |
|  |       |
|  |       |
|  |       |

| Child’s Current Living Arrangement |
| --- |
| Name of current location/placement:      |
| 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 |
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| Name:      | Email Address:      |
| Phone Number:      | Fax Number:      |

| Reason for Referral for Residential Treatment (detailed mental health information required in this section) |
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|       |

| Desired Outcomes of Residential Treatment  |
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|       |

| Summary of permanency plan goals for the child, including planned discharge placement  |
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|       |

| Checklist of required documents (mental health must be marked). This section must be filled out to process the referral. |
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| [ ]  Comprehensive Behavioral Health Assessment |
| [ ]  multidisciplinary team (MDT) meeting note (not required if referral is court ordered) |
| [ ]  Mental health treatment history, for at least the last 12 months |
| [ ]  Court Information: [ ]  Shelter Petition, [ ]  Shelter Order, [ ]  Judicial review, [ ]  Case Plan |
| [ ]  Individual Education Plan |
| [ ]  Evaluations: [ ]  Psychological, [ ]  Psychiatric, Psychosocial, [ ]  Psychosexual Evaluations |
| [ ]  Provider Clinical Notes, [ ]  counseling/Medication Management/ABA  |
| [ ]  Delinquency Information (DJJ, JDC, Probation, etc.) |
| **[ ]** Other (please specify):      |

| Additional Comments or Information |
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|       |

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.

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|  |  |       |
| Signature of Community based case worker |  | Date |

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| --- | --- | --- |
|  |  |       |
| Signature of Community based supervisor |  | Date |

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|  |  |       |
| Signature of community based director |  | Date |

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

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|  |  |       |
| Signature of SPOA |  | Date |