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: |  | | | |
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| 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 | | |
| --- | --- | --- |
| 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 |