Reconsideration – 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:      |
| Evaluator:      | Date of Last Suitability:      | Prior Recommendation:[ ]  In-Patient [ ]  STGH [ ]  Residential Not Recommended |
| Single Point of Access (SPOA) Contact Information |
| NAME:      | Phone number:      | EMAIL:      |

| 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:      |

| 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.)  |
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| **DESIRED TREATMENT OUTCOME** |
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| **SUMMARY OF PERMANENCY PLAN GOALS, INCLUDING PLANNED DISCHARGE PLACEMENT**  |
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| Current dsm-5 diagnosis |
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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 |
| [ ]  Mental health treatment history, INCLUDING updated Records since the time of the last assessment |
| [ ]  Court Information: [ ]  Shelter Petition, [ ]  Shelter Order, [ ]  Judicial review, [ ]  Case Plan |
| [ ]  Evaluations: [ ]  Psychological, [ ]  Psychiatric, Psychosocial, [ ]  Psychosexual Evaluations |
| [ ]  Treatment Provider documentation: [ ]  treatment plan, [ ]  counseling/Medication Management/ABA  |
| [ ]  Delinquency Information (DJJ, JDC, Probation, etc.) |

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

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| Signature of SPOA |  | Date |