

**REFERRAL FORM: BEHAVIORAL HEALTH CARE COORDINATION FOR CHILDREN AND YOUTH/ 1915i****Demographic Information****Youth Name:****Youth Phone:****Cell Phone:****Gender:****DOB:****Referral Date:****Address:****City:****Zip Code:****State:****MA#:****Parent/Legal Guardian(s)** (if legal guardian, a court order must be attached):**Parent/Guardian Phone:****Address (if different from child):****Parent/Guardian Cell:****Email:****Ethnicity, Race, Language, and Ability Status**

American Indian or Alaskan Native

Asian

Black or African American

Hispanic, Latine, or Spanish origin

White

Not Disclosed

Other:

**Primary Language:****Are interpreter services required?**

Yes

No

Deaf or Hearing Impaired

Blind or Visually Impaired

**Special Accommodations:****Living Situation:** Does this youth currently live or have a plan to live in a group home or any other congregate group setting other than a family or foster home?

Yes

No

**School/Education****Current School:****Current Grade:**

Not in School

**Special Education Services:** No Services

504 Plan

IEP

**Guidance Counselor:****Phone:****Behavioral Health** **Diagnosed By:****Diagnosis****ICD Code****Psychosocial/Environmental Elements Impacting Diagnosis:**

None

**Psychosocial/Environmental Element****ICD Code****Medical Diagnoses Impacting Behavioral Health Diagnosis:**

None

**Diagnosis****ICD Code****Current Medications** (please list names and dosages):

None

**Primary Physician:****Phone Number:****Person Making Referral:****Agency:****Phone:****Fax:****Email:****Reason for Referral:** 1915i Referral**Release of Information** (please review and have the parent/guardian sign the release):

I understand that I am applying for Care Coordination in \_\_\_\_\_ County. This service has been explained to me and I understand that if approved I will participate in the development of a Plan of Care with a team of people working with my family. I authorize the release of information to the Care Coordination Organization in \_\_\_\_\_ County so they can conduct a full screening and initiate an eligibility determination by the Administrative Service Organization (ASO) to determine my eligibility for Care Coordination services. I understand that I may revoke my permission at any time by written or verbal request.

**Signature of parent or legal guardian:****Date:****Witness signature:****Date:**

## Please indicate the level of care you intend to refer the youth to

### LEVEL I – GENERAL (must meet at least 2)

- A. Participant is not linked to behavioral health services, health coverage, or medical services;
- B. Participant lacks basic supports for education, income, shelter or food;
- C. Participant is transitioning from one level of intensity to another level of intensity of services;
- D. Participant needs care coordination services to obtain and maintain community-based treatment and services;
- E. Participant is currently enrolled in Level II or III Care Coordination services and has stabilized to the point that Level I is most appropriate

### LEVEL II – MODERATE (must meet at least 3)

- A. Participant is not linked to behavioral health services, health insurance, or medical services;
- B. Participant lacks basic supports for education, income, food, or transportation;
- C. Participant is homeless or at risk of homelessness
- D. Participant is transitioning from one level of intensity to another level of intensity of services including transitioning out of the following services:  
 (1) Inpatient psychiatric or substance use services      (2) RTC      (3) 1915(i) services under COMAR 10.09.89
- E. Due to multiple behavioral health stressors within the past 12 months, the participant has a history of:  
 (1) Psychiatric Hospitalizations, or  
 (2) Repeated visits or admissions to:      (a) Emergency room psychiatric units      (b) Crisis beds      (c) Inpatient psychiatric units
- F. Participant needs care coordination services to obtain and maintain community-based treatment and services;
- G. Participant is currently enrolled in Level III Care Coordination services and has stabilized to the point that Level II is most appropriate
- H. Participant is enrolled in Level I Care Coordination services and has experienced one of the following adverse childhood experiences during the preceding six months:  
 (1) Emotional, physical, or sexual abuse      (2) Emotional or physical neglect      (3) Significant family disruption or stressors

### LEVEL III – INTENSIVE (must meet the below criteria and submit a psychosocial assessment that addresses I-IX below)

The participant has a behavioral health disorder amenable to active clinical treatment, resulting from a face-to-face **psychosocial assessment by a licensed mental health professional**.

**Children ages 0 - 5** must receive a **score of 2 or higher** on the Early Childhood Services Intensity Instrument (ECSII). Children ages 0-5 who have a **score of 5** on the ECSII **do not** also have to meet the requirements listed below in order to be eligible. Children ages 0 - 5 who have a **score of 2, 3 or 4** on the ECSII **must meet one** of the following criteria:

Be **referred directly** from an Inpatient or day hospital unit, PCP, outpatient psychiatric facility, Early Childhood Mental Health (ECMH) Consultation program in daycare, Head Start, Early Head Start, Judy Hoyer Center, or home visiting program; -or-  
 If living in the community, have **1 or more** psychiatric inpatient or day hospitalizations, ER visits, crisis stabilization center visits, mobile crisis team responses, exhibit severe aggression, display dangerous behavior, been suspended or expelled or at risk of expulsion from school or childcare setting, display emotional and/or behavioral disturbance prohibiting their care by anyone other than their primary caregiver, at risk of out-of-home placement or placement disruption, have severe temper tantrums that place the child or family members at risk of harm, have trauma exposures and other adverse life events, or at risk of family-related risk factors including safety, parent-child relational conflict, and poor health and developmental outcomes **in the past 12 months**.

**Youth ages 6 - 21** must receive a **score of 2 or higher** on the Child and Adolescent Service Intensity Instrument (CASII). Youth ages 6 - 21 who have a **score of 5 or 6** on the CASII **do not** also have to meet the requirements listed below in order to be eligible. Youth ages 6 - 21 who have a **score of 2, 3 or 4** on the CASII **must meet one** of the following criteria:

Be living in the community and either:

Have **2 or more** inpatient psychiatric hospitalizations, ER visits, crisis stabilization center visits, or mobile crisis team responses **in the past 12 months**; -or-  
 Been in a residential treatment center (RTC) **within the past 90 days**.

**Level III referrals require submission of a psychosocial evaluation dated within 60 days of submission of the application. This evaluation must have an assignment of a Diagnostic and Statistical Manual (DSM) diagnosis or Diagnostic Criteria 0-5 (DC 0-5) and address the following:**

- I. Identifying information.
- II. Reason for referral.
- III. Reports reviewed to complete this referral.
- IV. **Risk of Harm-** Indicate child's or youth's potential to be harmed by others or cause significant harm to self or others.
- V. **Functional Status-** Indicate the degree to which the child or youth is able to fulfill responsibilities and interact with others. Include educational.
- VI. **Co-Occurrence of Conditions-** Developmental, medical, substance use, and psychiatric. Include DSM 5 diagnosis and medications, both current and past.
- VII. **Recovery Environment-** Indicate environmental factors that have the potential to impact the child's or youth's efforts to achieve or maintain recovery. Include description of family constellation and commitment.
- VIII. **Resiliency and/or Response to Services-** Indicate the child's or adolescent's ability to self-correct when there are disruptions in the environment. Include any major life changes and how the child or adolescent responded.
- IX. **Involvement in Services-** Indicate the quantity and quality of the child's/youth's and primary care taker's involvement in services. Include involvement with other agencies; list all inpatient and outpatient treatments, and out of home placements (i.e., group homes, shelters, foster care or RTCs).