

# REFERRAL FORM: BEHAVIORAL HEALTH CARE COORDINATION FOR CHILDREN AND YOUTH

DEMOGRAPHIC INFORMATION	Date of Referral:
<b>Youth Name:</b>	<b>Address:</b>
<b>Youth Phone:</b>	<b>City:</b>
<b>Cell Phone:</b>	<b>Zip Code:</b>
<b>Gender:</b>	<b>State:</b>
<b>DOB:</b>	<b>MA#:</b>

<b>Parent/Legal Guardian(s) (if legal guardian, a court order must be attached):</b>	
<b>Parent/Guardian Phone:</b>	<b>Address (if different from child):</b>
<b>Parent/Guardian Cell:</b>	<b>Email:</b>
<b><u>Ethnicity, Race, Language, and Ability Status</u></b>	
<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Asian
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Hispanic, Latine or Spanish origin
<input type="checkbox"/> White	<input type="checkbox"/> Not Disclosed
<input type="checkbox"/> Other:	
<b>Primary Language:</b>	<b>Are interpreter services required?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Deaf or hearing impaired	<input type="checkbox"/> Blind or Visually Impaired
<b>Special Accommodations:</b>	

<b>Living Situation:</b> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
---

<b><u>School/Education:</u></b>		
Current School:	Current Grade:	<input type="checkbox"/> Not in School
Special Education Services: <input type="checkbox"/> No Services <input type="checkbox"/> 504 Plan <input type="checkbox"/> 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:**

**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 that you intend to refer the youth** **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 CON documents outline in 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 3** on the Early Childhood Services Intensity Instrument (ECSII). Children ages 0 - 5 who have a **score of 3 or 4** on the ECSII must meet one of the following criteria:
- Be referred directly from an Inpatient or day hospital unit; Primary care provider (PCP); Outpatient psychiatric facility; Early Childhood Mental Health (ECMH) Consultation program in daycare; Head Start program; Judy Hoyer Center; or Home visiting program; or
  - If living in the community, have **1 or more** psychiatric inpatient or day hospitalizations; ER visits; exhibit severe aggression; display dangerous behavior; been suspended from school or childcare setting; display emotional 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 3 or higher** on the Child and Adolescent Service Intensity Instrument (CASII). Youth ages 6 -21 whose CASII **scores fall between 3-5** must meet one of the following criteria:
- Be transitioning from a residential treatment center; or
  - Be living in the community and:
    - Have any combination of 2 or more inpatient psychiatric hospitalizations or emergency room visits in the past 12 months; or
    - Have been in an RTC within the past 90 days

**Level III referrals require submission of a psychosocial evaluation dated within 30 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).

## Care Coordination Organization Contacts

<b>Jurisdiction</b>	<b>CCO Name</b>	<b>CCO Phone #</b>	<b>CCO Fax#/ Email</b>
Allegany	Potomac Case Management	301-791-3087	301-393-0730
Anne Arundel	Center for Children	301-609-9887	301-609-7284
Baltimore City	Empowering Minds Resource Center	410-625-5088	410-625-4890
	Hope Health Systems	410-265-8737	410-265-1258 ccoreferral@hopehealthsystems.com
	Optimum Maryland	410-233-6200	410-233-6201
	Volunteers of America	240-579-6698	301-560-8505
	Wraparound Maryland	443-449-7713	443-451-8268
Baltimore County	Hope Health Systems	410-265-8737	410-265-1258 ccoreferral@hopehealthsystems.com
Calvert	Center for Children	410-535-3047	410-535-3890
Caroline	Wraparound Maryland	410-690-4805	410-690-4806
Carroll	Potomac Case Management	443-244-4113	443-293-7086
Cecil	Advantage Psychiatric Services	410-686-3629 Ext. 409	410-780-7178
Charles	Center for Children	301-609-9887	301-609-7284
Dorchester	Wraparound Maryland	410-690-4805	410-690-4806
Frederick	Potomac Case Management	443-244-4113	240-578-4885
Garrett	Burlington United Methodist Family Services	301-334-1285	301-334-0668
Harford	Empowering Minds Resource Center	443-484-2306	443-484-2970
Howard	Center for Children	301-609-9887	301-609-7284
Kent	Wraparound Maryland	410-690-4805	410-690-4806
Montgomery	Volunteers of America	240-696-1565	301-306-5105
Prince George's	Center for Children	301-609-9887	301-609-7284
Queen Anne's	Wraparound Maryland	410-690-4805	410-690-4806
St. Mary's	Center for Children	301-475-8860	301-475-3843
Somerset	Wraparound Maryland	410-219-5070	410-219-5072
Talbot	Wraparound Maryland	410-690-4805	410-690-4806
Washington	Potomac Case Management	301-791-3087	301-393-0730
Wicomico	Wraparound Maryland	410-219-5070	410-219-5072
Worcester	Wraparound Maryland	410-219-5070	410-219-5072

last updated August 15, 2022