REFERRAL FORM: BEHAVORAL HEALTH CARE COORDINATION FOR CHILDREN AND YOUTH

Demographic Information

Youth Name: **Referral Date:**
Youth Phone: **Address:**
Cell Phone: **City:**
Gender: **Zip Code:**
DOB: **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:

Psychosocial/Environmental Element	ICD Code
☐ None	

Medical Diagnoses Impacting Behavioral Health Diagnosis:

Diagnosis	ICD Code

☐ None

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 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 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 ESCII 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

Jurisdiction	*CCO Name*	*CCO Phone #*	*CCO Fax#/ Email*
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