REFERRAL FORM: BEHAVIORAL HEALTH CARE COORDINATION FOR CHILDREN AND YOUTH/ 1915i

DEMOGRAPHIC INFORMATION	**Date of Referral:**
Youth Name:	**Address:**
Youth Phone:	**City:**
Cell Phone:	**Zip Code:**
Gender:	**State:**
DOB:	**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 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 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 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 3 or higher*** on the Child and Adolescent Service Intensity Instrument (CASII). Youth ages 6-21 who have a ***score of 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 3-5*** 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 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 (CCO) Contacts

Jurisdiction	*CCO Name*	*CCO Phone #*	*CCO Fax#/ Referral Email*
Allegany	Potomac Community Services	301-791-3087	301-393-0730
Anne Arundel	BTST Services	301-477-3339	443-773-5624 / referrals@btstservices.com
	Empowering Minds Resource Center	410-590-3672	410-590-3670 / referralaa@emrcgroup.org
Baltimore City	Baltimore Crisis Response	443-835-3425	443-835-3025 / cmrefer@bcresponse.org
	Empowering Minds Resource Center	410-625-5088	410-625-4890 / referral@emrcgroup.org
	Hope Health Systems	410-265-8737	410-265-1258 / ccoreferral@hopehealthsystems.com
	Leading By Example	443-438-7614	443-835-4776 / referrals@leadingbyexamplellc.com
	Optimum Maryland	410-233-6200	410-233-6201
	You First Health Systems	301-329-0177	301-825-9777 / info@youfirsthealthsystems.com
Baltimore County	Hope Health Systems	410-265-8737	410-265-1258 / ccoreferral@hopehealthsystems.com
	Wraparound Maryland	443-449-7713	443-451-8268
Calvert	Center for Children	410-535-3047	410-535-3890
Caroline	Wraparound Maryland	410-690-4805	410-690-4806
Carroll	Potomac Community Services	301-791-3087	301-393-0730
Cecil	Advantage Psychiatric Services	410-686-3629 Ext. 409	410-780-7178
Charles	InnerSourced Solutions	240-207-4513	240-846-6037 / ccoreferrals@innersourcedsolutions.com
Dorchester	Wraparound Maryland	410-690-4805	410-690-4806
Frederick	Potomac Community Services	301-791-3087	301-393-0730
Garrett	Burlington United Methodist Family Services	301-334-1285	301-334-0668
Harford	Empowering Minds Resource Center	443-484-2306	443-484-2970 / referralhc@emrcgroup.org
Howard	Center for Children	301-609-9887	301-609-7284 / CCOreferralsHOWARD@center-for-children.org
Kent	Wraparound Maryland	410-690-4805	410-690-4806
Montgomery	Advanced Behavioral Health	301-345-1022	301-560-5558 / vkurdian@abhmaryland.com
	Volunteers of America	240-696-1565	301-306-5105
Prince George's	BTST Services	301-477-3339	443-773-5624 / referrals@btstservices.com
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 Community Services	301-791-3087	301-393-0730
Wicomico	Wraparound Maryland	410-219-5070	410-219-5072
Worcester	Wraparound Maryland	410-219-5070	410-219-5072

Should you require additional assistance or need information or clarification about services in your jurisdiction, please contact your Local Behavioral Health Authority/Core Service Agency (LBHA/CSA). A full directory of LBHAs/CSAs is available at https://mabha.org/getting-help/.

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