

REFERRAL FORM: BEHAVIORAL HEALTH CARE COORDINATION FOR CHILDREN AND YOUTH

DEMOGRAPHIC INFORMATION	Date of Referral: _____
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Youth Name: Youth Phone: Cell Phone: Gender <input type="checkbox"/> M/ <input type="checkbox"/> F <input type="checkbox"/> DOB:	Address: City: Zip Code: State MA#
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Parent/Legal Guardian(s) (if legal guardian, a court order must be attached):	
Address (if different from child):	Cell:
Parent/Guardian Phone:	Email:

Ethnicity/Race	
<input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Hispanic, Latino or Spanish origin <input type="checkbox"/> Not Available	
Primary Language:	
Are interpreter services required? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Deaf or hearing impaired	
<input type="checkbox"/> Blind	
Special Accommodations:	

School/Education:			
Current School:	Current Grade:	Not in School	
Special Education Services: <input type="checkbox"/> Yes <input type="checkbox"/> No	IEP <input type="checkbox"/>	504 Plan <input type="checkbox"/>	
Guidance Counselor: Phone:			

Living Situation: Does this youth currently live in or have a plan for placement in a group home or any other congregate group setting other than a family home or foster home? <input type="checkbox"/> Yes <input type="checkbox"/> No

Behavioral Health Diagnosis Diagnosed By:

Diagnosis	DSM 5/ ICD Code
a.	
b.	
c.	

Medical Diagnoses Impacting Behavioral Health Diagnosis: None

Diagnosis	DSM5/ ICD code
a.	
b.	
c.	

Psychosocial/ Environmental Elements Impacting Diagnosis: None

Diagnosis	DSM 5/ ICD Code
a.	
b.	
c.	

Current Medication: None

Name	Dosage
a.	
b.	
c.	

Primary Physician:

Phone Number:

Reason for Referral: (Please provide a brief explanation of the level the child/youth is being referred)

Release of Information: (please review and have the parent/guardian sign the release)

I understand that I am applying for Care Coordination in. This service has been explained to me and I understand that if approved I will participate in 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 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:

Name of Person Making Referral:

Agency:

Phone:

FAX:

E-Mail :

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 and 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;

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; OR
 - (3) 1915(i) services under COMAR 10.09.89
- E. Due to multiple behavioral health stressors within the past 12 month, the participant has a history of:
 - (1) of psychiatric hospitalizations, or
 - (2) repeated visits or admissions to:
 - (a) Emergency room psychiatric units;
 - (b) crisis beds; or
 - (c) inpatient psychiatric units ;
- F. Participant needs care coordination services to obtain and maintain community- based treatment and services;

Level III- INTENSIVE - must meet at least 1 of the below criteria and submit CON documents outlined in I-IX below.

- A. Participant shall meet the following criteria to be eligible based on their impaired functioning and service intensity level:
 - (1) Transitioning from RTC to the community; or
 - (2) Living in the community: and;
 - (a) Be at least 13 years old and have:
 - (i) 3 or more inpatient psychiatric hospitalizations in past 12 month; or
 - (ii) been in RTC within the past 90 calendar days; or
 - (b) Be 6 through 12 years old and have:
 - (i) 2 or more inpatients psychiatric hospitalizations in past 12 months; or
 - (ii) been in RTC within the past 90 calendar days
- B. Youth who *are younger than 6 years* old shall either:
 - (1) Be referred directly from an inpatient hospital unit; or
 - (2) If living in the community, have 2 or more psychiatric inpatient hospitalizations in the past 12 months

Level 3 referrals require submission of a psychosocial evaluation and a psychiatric evaluation dated within 30 days prior to submission of application. This evaluation must address the following:

- I. Identifying information.
- II. Reason for referral.
- III. Reports reviewed to complete this referral.
- IV. **Risk of Harm**- Indicate child’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 adolescent 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 a 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 or adolescents 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/youth 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)

If you require additional assistance or need further information or clarification about the services, you may contact your local county Core Service Agency. See contact info on the last page.

Care Coordination Organization Contacts

Jurisdiction	CCO Name	CCO Phone #	CCO Fax#
Allegany	Pressley Ridge of Western MD	301-724-8413	301-724-8417
Anne Arundel	Center for Children	301-609-9887	301-609-7284
Baltimore City	Alliance, Inc.	410-282-5900 - X1204	410-675-4996
	Hope Health Systems	410-265-8737	410-265-1258
	Partnership Development Group (PDG)	410-863-7213 - x165	410-863-7205
	Wraparound Maryland	443-449-7713	443-451-8268
Baltimore County	Alliance, Inc.	410-282-5900	410-282-1788
Calvert	Center for Children	410-535-3047	410-535-3890
Caroline	Maryland Choices	443-759-8865	866-582-2034
Carroll	Potomac Case Management	443-244-4113	240-578-4885
Cecil	Upper Bay Counseling & Support Services	410-996-3450	410-398-3458
Charles	Center for Children	301-609-9887	301-609-7284
Dorchester	Maryland Choices	443-759-8865	866-582-2034
Frederick	Potomac Case Management	443-244-4113	240-578-4885
Garrett	Burlington United Methodist Family Services	301-334-1285	301-334-0668
Harford	Alliance, Inc.	410-273-1399 press "0"	410-273-2085
Howard	Alliance, Inc.	410-282-5900 -X1204	410-675-4996
Kent	Maryland Choices	443-759-8865	866-582-2034
Montgomery	TBD	N/A	N/A
Prince George's	Alek's House	301-429-6100	301-429-1333
	Volunteer of America	301-306-0904	301-306-5705
Queen Anne	Maryland Choices	443-759-8865	866-582-2034
St. Mary's	Center for Children	301-475-8860	301-475-3843
Somerset	Worcester Co Health Dept	410-632-9230	410-632-9239
Talbot	Maryland Choices	443-759-8865	866-582-2034
Washington	Potomac Case Management	301-791-3085	301-393-0730
Wicomico	Wraparound Maryland	410-219-5070	410-219-5072
Worcester	Worcester Co Health Dept	410-632-9230	410-632-9239

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ALLEGANY COUNTY Allegany Co. Mental Health System's Office P.O. Box 1745 Cumberland, Maryland 21501-1745 Phone: 301-759-5070 Fax: 301-777-5621	ANNE ARUNDEL COUNTY Anne Arundel County Mental Health Agency PO Box 6675, MS 3230, 1 Truman Parkway, 101 Annapolis, Maryland 21401 Phone: 410-222-7858 Fax: 410-222-7881
BALTIMORE CITY Behavioral Health System Baltimore One North Charles Street, Suite 1300 Baltimore, Maryland 21201-3718 Phone: 410-637-1900 Fax: 410-637-1911	BALTIMORE COUNTY Bureau of Behavioral Health of Baltimore County Health Department 6401 York Road, Third Floor Baltimore, Maryland 21212 Phone: 410-887-3828 Fax: 410-887-3786
CALVERT COUNTY Calvert County Core Service Agency P.O. Box 980 Prince Frederick, Maryland 20678 Phone: 410-535-5400 #330 Fax: 410-414-8092	CARROLL COUNTY Carroll County Health Department Bureau of Prevention, Wellness, and Recovery 290 South Center Street Westminster, Maryland 21158-0460 Phone: 410-876-4800 Fax: 410-876-4832
CECIL COUNTY Cecil County Core Service Agency 401 Bow Street Elkton, Maryland 21921 Phone: 410-996-5112 Fax: 410-996-5134	CHARLES COUNTY Department of Health Core Service Agency P.O. Box 1050, 4545 Crain Hwy. White Plains, Maryland 20695 Phone: 301-609-5757 Fax: 301-609-5749
FREDERICK COUNTY Mental Health Management Agency of Frederick County 22 South Market Street, Suite 8 Frederick, Maryland 21701 Phone: 301-682-6017 Fax: 301-682-6019	GARRETT COUNTY Garrett County Core Service Agency 1025 Memorial Drive Oakland, Maryland 21550-1943 Phone: 301-334-7440 Fax: 301-334-7441
HARFORD COUNTY Office on Mental Health of Harford County 125 N Main Street Bel Air, Maryland 21014 Phone: 410-803-8726 Fax: 410-803-8732	HOWARD COUNTY Howard County Mental Health Authority 9151 Rumsey Road, Suite 150 Columbia, Maryland 21045 Phone: 410-313-7350 Fax: 410-313-7374
MID-SHORE COUNTIES (Includes Caroline, Dorchester, Kent, Queen Anne and Talbot Counties) Mid-Shore Mental Health Systems, Inc. 28578 Mary's Court, Suite 1 Easton, Maryland 21601 Phone: 410-770-4801 Fax: 410-770-4809	MONTGOMERY COUNTY Department of Health & Human Services, Montgomery County Government 401 Hungerford Drive, 1st Floor Rockville, Maryland 20850 Phone: 240-777-1400 Fax: 240-777-1145
PRINCE GEORGE'S COUNTY Prince George's County Health Department Behavioral Health Services Prince George's County Core Service Agency 9314 Piscataway Road Clinton, Maryland 20735 Phone: 301-856-9500 Fax: 301-324-2850	ST. MARY'S COUNTY St. Mary's County Dept. of Aging and Human Services 23115 Leonard Hall Drive, P.O. Box 653 Leonardtown, Maryland 20650 Phone: 301-475-4200 ext. 1682 Fax: 301-475-4000
WASHINGTON COUNTY Washington County Mental Health Authority 339 E. Antietam Street, Suite #5 Hagerstown, Maryland 21740 Phone: 301-739-2490 Fax: 301-739-2250	WICOMICO/SOMERSET COUNTIES Wicomico Behavioral Health Authority/Somerset Core Service Agency 108 East Main Street Salisbury, Maryland 21801 Phone: 410-543-6981 Fax: 410-219-2876
WORCESTER COUNTY Worcester County Core Service Agency P.O. Box 249 Snow Hill, Maryland 21863 Phone: 410-632-3366 Fax: 410-632-0065	

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