**Department for Community Based Services**

**Community Mental Health Center (CMHC) Referral Form**

**The information requested below is required for the initial intake appointment. Additional information may be requested.**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client’s Information** | | | | | | | Name: | | | | | | | |
| Sex: | | DOB: | | | | | SSN: | | | | | | | |
| Address: | | | | | | | Phone: | | | | | | | |
| City: | | County: | | | | | State: | | | | | Zip: | | |
|  | | | | | | | | | | | | | | |
| Parental Custody  Name:  Phone: | | Kinship Care/Relative Placement  Name:  Phone:  Effective Date: | | | | | | DCBS Custody/Foster Care  Worker name:  Phone: | | | | | | Custodian name:  Phone:  Effective Date: |
| Client’s Daycare/Preschool/School Name: | | | | | | | | | | | | | | |
| Previous MH/SA Treatment: Yes No | | | | If yes, previous provider:  Phone: | | | | | | | | | | |
| Reason for referral/presenting problem for treatment *(Please indicate if Michelle P assessment is requested)*: | | | | | | | | | | | | | | |
| Substance abuse  Anger management  Depression | | | | Peer problems  Anxiety | | | | | | | Traumatic life event  Unable to focus | | | |
| CMHC Documentation or Follow-up Requested by DCBS Worker: | | | | | | Report for the Court | | | | | | | Summary of Assessment | |
| Monthly Summary of Services | | Notification of Kept Initial Appointment | | | | Overall Service Summary for Report for DCBS Case | | | | | | | Other (Please Specify): | |
|  | | | | | | | | | | | | | | |
| Client’s Insurance:  Medicaid  Medicare  Private Insurance  None:(Sliding Scale Fee)  Please indicate which MCO or Private Insurance Company client is covered by: | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **DCBS Information** | | | Is individual court-ordered for services? Yes  No  *If yes, please attach court order.* | | | | | | Is individual currently involved in court process?  Yes  No  Next Court Date: | | | | | |
| Worker Name: | | |
| Phone: | | |
| Type of maltreatment: | | | Case name: | | | | | | | | | | | |
| Physical Abuse | Sexual Abuse | | CDW Worker: | | | | | | | | | | | |
| Emotional Injury | Neglect | | Phone: | | | | | | | | | | | |
| Exploitation | Dependency | | Referred by DPP Staff: | | | | | | | | | | | |
|  | | | County: | | | | | | Phone: | | | | | |
| Please ensure the following items are submitted with this referral form or are brought to the client’s initial intake appointment: | | | | | | | | | | | | | | |
| List of current medications client takes  Client’s Medicaid, Medicare or Private Insurance Card  Current court orders relating to client’s case | | | | | Court orders regarding guardianship, custody or care of the  client  Placement log from TWIST, if applicable | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| *The referring DCBS employee should attend the first session.*  *CMHC cannot provide treatment without current Guardian’s signature on intake forms due to HIPAA and other state and federal regulatory requirements. If the individual being referred is a minor or an adult who has a court-appointed guardian, CMHC must have information indicating the person with authority over the referred individual who can sign for treatment. Any Custody Orders, Divorce Decree or Guardianship orders with individual responsible for medical treatment and that person’s current contact information should be included with the submission of this referral form. Additionally, if in foster care, DCBS must sign for consent for treatment.* | | | | | | | | | | | | | | |
| Please indicate the name of the person attending the first session and who is authorized to consent for treatment: | | | | | | | | | | | | | | |
| **DCBS Worker Signature:** | | | | | | | | | | **Date:** | | | | |