NBFS Mental Health Services—Referral Form

DATE OF REFERRAL:							
PROGRAM:		Intensive In-Home Services		MHSS		Other	

CLIENT DEMOGRAPHIC, INSURANCE, AND DIAGNOSTIC INFORMATION			
Name:		Date of Birth:	
Address:			
Contact #:		Gender:	
Alternate #:		Race:	
Social Security Number:		Medicaid Number:	
Medicaid Type:			

PARENT/LEGAL GUARDIAN/AUTHORIZED REPRESENTATIVE (If applicable)					
Name:				Relationship:	
Address:					
Home Phone:		Cell Phone:		Work Phone:	

Chief Complaint/Presenting Problem:	

DIAGNOSTIC INFORMATION:	

PLEASE CHECK ALL PROBLEM AREAS THAT APPLY TO THIS CLIENT:							
	Depression		Violence/property destruction		Noncompliance/Defiance		Substance/Alcohol Use/Abuse
	Anger/Aggression		Family/Relationship Issues		Suicidality		Gang involvement
	Anxiety		Medication Management		Difficulty Sleeping/Eating		Legal involvement
	Expressing Feelings/Emotions		Stabilize Psychiatric Symptoms		Self-harm		Other:

	DMAS and DBHDS CRITERIA FOR IIH (Must meet 2 of the 3 criteria below)
	The individual is experiencing repeated behavioral/mental health concerns in the home, school, and community that are placing him/her at risk of out of home placement or to a higher level of care?
	The individual's behaviors/concerns have required repeated interventions (outpatient, med mgt., probation, IEP, CPS/Foster Care, etc.)
	The individual has impaired cognition such that he/she places others and themselves at risk of harm or injury (lacks remorse, deliberate acting out, repeated behaviors despite consequences, not learning from mistakes, etc.)
	OTHER REQUIREMENTS FOR PARTICIPATION:
	At least one (1) parent/guardian is willing to participate in services
	The individual (client) is willing to participate in services
	The individual and parent/guardian agree to a referral for outpatient services as required by regulations (*only if not already receiving*)

REFERRING PARTY NAME:		REFERRING AGENCY:	
MAILING ADDRESS:			
TELEPHONE NUMBER:		E-MAIL ADDRESS:	

DISPOSITION

INDIVIDUAL MEETS CRITERIA (YES or NO)		DATE/TIME OF INTAKE:	
PRE-AUTH NEEDED? (YES OR NO):		ACTIVE INSURANCE COVERAGE? (YES OR NO):	
DATE PRE-AUTH REQUESTED:		CCC+ or Medallion 4.0:	
DATE APPROVAL RECEIVED:		ASSIGNED COUNSELOR:	
CLINICAL SUPERVISOR:		START DATE:	