COMMUNITY SPECIALIZED SERVICES, INC.

SCREENING/REFERRAL FOR SERVICES

Date of Referral:_____ Date Service Needed:_____ County of Residence :_____

Service Requested:___B-3 Respite ___Therapeutic Foster Care ___Family Foster Care ___Integrated Care CoCM

Client's Name:_____ Date of Birth:_____ Record Number:_____
Race:_____ Age:_____ Gender:_____
Current Place of Residence:_____

Medicaid: Yes /No (if "Yes", provide number):_____
Medicare: Yes /No (if "Yes", provide number):_____
Health Choice: Yes/No (if "Yes", provide number):_____
Private Insurance: Yes/No (if "Yes", insurance company name and policy number):_____
_____

Referral Source Name:_____ Phone#_____
Referral Source Agency:_____

Guardian Name:_____ Phone#_____
Guardian Address:_____

Is child currently in DSS custody? ____Yes ____No If "yes", answer the following:
DSS County with custody:_____ Main DSS Phone#:_____
DSS case worker's name:_____ Phone Number:_____

Describe in detail why you are referring child for services:_____
_____
_____
_____

List Diagnosis:_____
_____
_____

Please check applicable boxes:
Sexually Aggressive (describe behaviors):_____
_____
_____
Dually/multiply diagnosed (describe behaviors): _____
_____
_____

Medications ___ Yes or ___No (list name & dosage):_____
_____

Medical Issues ___Yes or ___No (ie. allergies, diabetic, etc.):_____
_____

Current school placement & grade level:_____

Is the client involved with:

DSS (contact name and number):_____

Juvenile Justice (contact name and number):_____

EC/School System (contact name and number):_____

Mental Health –LME (contact name and number):_____

MH/SA/DD Provider Agency (agency name, contact nane and number):_____

_____

Primary Care Physician (practice, doctor and number):_____

Other:_____

Do any of the following listed below apply? Yes or No (Must explain all boxes checked below)

Utilizing or having utilized acute crisis intervention services in the past year to maintain community placement;

Having had 3 or more state hospitalizations in the past year or at least 1 hospitalization of 60 continuous days within past year;

Having had DSS substantiated abuse, neglect or dependency in the past year;

Having been expelled from 2 or more daycare or pre-kindergarten situations within the past year;

Having been convicted of a felony or 2 or more serious misdemeanors in juvenile /adult court or being currently placed in a youth advocacy program (training school), prison, juvenile detention center, or jail- any within the past year;

Situation exacerbated by special needs, (e.g. physical disability that substantially interferes with functioning)

Must explain in detail all boxes checked above:

_____

_____

_____

_____

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_____

_____

_____

Accepted. Foster Parent Identified:_____

Denied & Reason:_____

_____

_____

Comments/ Restrictions:_____

_____

_____

_____

Person Completing Referral:_____ **Date:**_____

Name & Title