Children and Family Treatment and Support Services Referral Form

Date of Referral: _____

Please note that this is NOT a required form but a template created for use if preferred

Updated by the RPC: 1/14/19

Person Making Referral	**First Name**		**Last Name**	
	Agency Name		**Phone #**	
	Address		**Email**	
Health Home Care Coordinator Information *if applicable	**First Name**		**Last Name**	
	Agency Name		**Phone #**	
	Address		**Email**	
Participant Information	**First Name**		**Last Name**	
	Gender	☐ **Male** ☐ **Female**	**Date of Birth**	
	Caregiver		**Primary Language**	
	Phone #		**Alternate Phone #**	
	Email		**County**	
	Address			

Participant Health Care Information	**Managed Care Organization (MCO)**		**MCO ID #**	
	MCO Contact Name		**MCO Phone Number**	
	MCO Contact Email		**Medicaid CIN Number**	
	Primary Diagnosis & ICD 10 Code		**Secondary Diagnosis & ICD 10 Code**	

Any Known Safety Concerns? *(Criminal Record, History of Violence, Weapons in the Home, Sex Offender, General Concerns, etc.):* ☐ *N/A*

Referred CFTSS Service(s):

☐ **Other Licensed Practitioner (OLP)**	☐ **Psychosocial Rehabilitation (PSR)**
☐ **Community Psychiatric Supports and Treatment (CPST)**	☐ **Family Peer Support Services (FPSS)**
☐ **Youth Peer Support and Training (YPST)**	☐ **Crisis Intervention (CI)**

Any additional information that may be important to know:

Any Identified Service Restrictions Surrounding Client Availability:

Below sections are for CFTSS Service Provider Affiliate to Complete: ***Date Received:***

CFTSS Provider/Supervisor Assigned		***Date Assigned***	

CFTSS AGENCY INFORMATION:

AGENCY NAME: _____ **POINT OF CONTACT:** _____

PHONE: _____ **FAX:** _____

E-MAIL: _____

Additional Resources

For Referring Individuals:

Items you may want to include with your referral packet:

- Signed releases
- Preliminary Plan of Care
- Medical Necessity Documentation
- Other Pertinent Family Information