Referral Form: TCM Plus

*** Please complete the form in its entirety. Enter "N/A" for sections that are not applicable. ***

Youth's Name: _____ **Date of Referral:** _____

Street Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Youth's Cell Phone: _____ **Youth's Alternate Phone:** _____

Identified Gender: ☐ **Male** ☐ **Female** **Insurance Type:** ☐ **Medical Assistance** ☐ **Private** ☐ **Uninsured**

Date of Birth: _____ **Age:** _____ **MA#/Insurance Provider:** _____

Name(s) of Parent(s) or Legal Guardian(s) (if legal guardian, a court order must be attached):

_____

Address (if different from youth): _____ **E-Mail:** _____

Parent(s)'/Guardian(s)' Phone: _____ **Alternate Phone:** _____

Ethnicity, Race, and Language

☐ **Not Available** ☐ **American Indian or Alaskan Native** ☐ **Asian** ☐ **Black or African American**

☐ **Hispanic, Latinx, or Spanish origin** ☐ **Native Hawaiian or Pacific Islander** ☐ **White**

Primary Language: _____ **Are interpretation services required?** ☐ **Yes** ☐ **No**

Deaf or hearing impaired: ☐ **Yes** ☐ **No** **Blind or visually impaired:** ☐ **Yes** ☐ **No**

Special Accommodations: _____

Living Situation: Does this youth currently live or have a plan to live in a group home or any other congregate group setting other than a family or foster home? ☐ **Yes** ☐ **No**

School / Education

Is this youth enrolled in school? ☐ **Yes** ☐ **No** **If yes, school name:** _____

Grade: ____ **Eligible for Special Education Services:** ☐ **Yes** ☐ **No** **IEP/504 Plan:** ☐ **Yes** ☐ **No**

Behavioral Health Diagnosis

Does this youth have a behavioral health diagnosis? ☐ **Yes** ☐ **No** **DSM 5 / ICD 10 Code:** _____

Diagnosed by: _____ **Name of Diagnosis:** _____

Reason for Referral

Please provide a brief explanation of the reasons why the child/youth is referred based on TCM Plus eligibility criteria:

Release of Information (please review and have a parent or legal guardian sign the release):

I understand that I am applying for Care Coordination and additional supports in (county name): _____. 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 Behavioral Health Administration so they can conduct an eligibility determination for TCM Plus services and to the Maryland Coalition of Families to facilitate the engagement of a family or peer support partner. 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 Name:** _____

E-Mail: _____ **Phone:** _____ **Fax:** _____

Please send the referral securely to Candice.Adams@maryland.gov or fax to (410) 402-8601

BHA Use Only

Received By: _____ **Date:** _____ **Status:** ☐ **Approved** ☐ **Denied**

Reason for Denial: _____

Additional Comments:

For assistance or further information/clarification about services, please contact your local LBHA/CSA.