

REFERRAL FORM: BEHAVIORAL HEALTH CARE COORDINATION FOR CHILDREN AND YOUTH/ 1915i

DEMOGRAPHIC INFORMATION	Date of Referral:
Youth Name:	Address:
Youth Phone:	City:
Cell Phone:	Zip Code:
Gender:	State:
DOB:	MA#:

Parent/Legal Guardian(s) (if legal guardian, a court order must be attached):	
Parent/Guardian Phone:	Address (if different from child):
Parent/Guardian Cell:	Email:
Ethnicity, Race, Language, and Ability Status	
<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Asian
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Hispanic, Latine or Spanish origin
<input type="checkbox"/> White	<input type="checkbox"/> Not Disclosed
<input type="checkbox"/> Other:	
Primary Language:	Are interpreter services required? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Deaf or hearing impaired	<input type="checkbox"/> Blind or Visually Impaired
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? <input type="checkbox"/> Yes <input type="checkbox"/> No

School/Education:		
Current School:	Current Grade:	<input type="checkbox"/> Not in School
Special Education Services: <input type="checkbox"/> No Services <input type="checkbox"/> 504 Plan <input type="checkbox"/> IEP		
Guidance Counselor:	Phone:	

Behavioral Health Diagnosed By:

Diagnosis	ICD Code

Psychosocial/ Environmental Elements Impacting Diagnosis: None

Psychosocial/Environmental Element	ICD Code

Medical Diagnoses Impacting Behavioral Health Diagnosis: None

Diagnosis	ICD Code

Current Medications (please list names and dosages): None

Primary Physician:

Phone Number:

Person Making Referral:

Agency:

Phone:

Fax:

Email:

Reason for Referral:

1915i Referral

Release of Information (please review and have the parent/guardian sign the release):

I understand that I am applying for Care Coordination in _____ County. This service has been explained to me and I understand that if approved I will participate in the development of a Plan of Care with a team of people working with my family. I authorize the release of information to the Care Coordination Organization in _____ County so they can conduct a full screening and initiate an eligibility determination by the Administrative Service Organization (ASO) to determine my eligibility for Care Coordination services. 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:

Please indicate the level of care that you intend to refer the youth **Level I - General** (*must meet at least 2*)

- A. Participant is not linked to behavioral health services, health coverage, or medical services;
- B. Participant lacks basic supports for education, income, shelter or food;
- C. Participant is transitioning from one level of intensity to another level of intensity of services;
- D. Participant needs care coordination services to obtain and maintain community-based treatment and services;
- E. Participant is currently enrolled in Level II or III Care Coordination services and has stabilized to the point that Level I is most appropriate

 Level II - Moderate (*must meet at least 3*)

- A. Participant is not linked to behavioral health services, health insurance, or medical services;
- B. Participant lacks basic supports for education, income, food, or transportation;
- C. Participant is homeless or at risk of homelessness
- D. Participant is transitioning from one level of intensity to another level of intensity of services including transitioning out of the following services:
 - (1) Inpatient psychiatric or substance use services (2) RTC (3) 1915(i) services under COMAR 10.09.89
- E. Due to multiple behavioral health stressors within the past 12 months, the participant has a history of:
 - (1) Psychiatric Hospitalizations, or
 - (2) Repeated visits or admissions to: (a) Emergency room psychiatric units (b) Crisis beds (c) Inpatient psychiatric units
- F. Participant needs care coordination services to obtain and maintain community-based treatment and services;
- G. Participant is currently enrolled in Level III Care Coordination services and has stabilized to the point that Level II is most appropriate
- H. Participant is enrolled in Level I Care Coordination services and has experienced one of the following adverse childhood experiences during the preceding six months:
 - (1) Emotional, physical, or sexual abuse (2) Emotional or physical neglect (3) Significant family disruption or stressors

 Level III - Intensive (*must meet the below criteria and submit CON documents outline in I-IX below*)

- The participant has a behavioral health disorder amenable to active clinical treatment, resulting from a face-to-face **psychosocial assessment by a licensed mental health professional**
- Children ages 0 - 5** must receive a **score of 3** on the Early Childhood Services Intensity Instrument (ECSII). Children ages 0 - 5 who have a **score of 3 or 4** on the ECSII must meet one of the following criteria:
- Be referred directly from an Inpatient or day hospital unit; Primary care provider (PCP); Outpatient psychiatric facility; Early Childhood Mental Health (ECMH) Consultation program in daycare; Head Start program; Judy Hoyer Center; or Home visiting program; or
 - If living in the community, have **1 or more** psychiatric inpatient or day hospitalizations; ER visits; exhibit severe aggression; display dangerous behavior; been suspended from school or childcare setting; display emotional or behavioral disturbance prohibiting their care by anyone other than their primary caregiver; at risk of out-of-home placement or placement disruption; have severe temper tantrums that place the child or family members at risk of harm; have trauma exposures and other adverse life events; or at risk of family-related risk factors including safety, parent-child relational conflict, and poor health and developmental outcomes in the past 12 months
- Youth ages 6 - 21** must receive a **score of 3 or higher** on the Child and Adolescent Service Intensity Instrument (CASII). Youth ages 6 -21 whose CASII **scores fall between 3-5** must meet one of the following criteria:
- Be transitioning from a residential treatment center; or
 - Be living in the community and:
 - Have any combination of 2 or more inpatient psychiatric hospitalizations or emergency room visits in the past 12 months; or
 - Have been in an RTC within the past 90 days

Level III referrals require submission of a psychosocial evaluation dated within 30 days of submission of the application. This evaluation must have an assignment of a Diagnostic and Statistical Manual (DSM) diagnosis or Diagnostic Criteria 0-5 (DC 0-5) and address the following:

- I. Identifying information.
- II. Reason for referral.
- III. Reports reviewed to complete this referral.
- IV. **Risk of Harm** - Indicate child's or youth's potential to be harmed by others or cause significant harm to self or others.
- V. **Functional Status** - Indicate the degree to which the child or youth is able to fulfill responsibilities and interact with others. Include educational.
- VI. **Co-Occurrence of Conditions** - Developmental, medical, substance use, and psychiatric. Include DSM 5 diagnosis and medications, both current and past.
- VII. **Recovery Environment** - Indicate environmental factors that have the potential to impact the child's or youth's efforts to achieve or maintain recovery. Include description of family constellation and commitment.
- VIII. **Resiliency and/or Response to Services** - Indicate the child's or adolescent's ability to self-correct when there are disruptions in the environment. Include any major life changes and how the child or adolescent responded.
- IX. **Involvement in Services** - Indicate the quantity and quality of the child's/youth's and primary care taker's involvement in services. Include involvement with other agencies; list all inpatient and outpatient treatments, and out of home placements (i.e., group homes, shelters, foster care or RTCs).

Care Coordination Organization (CCO) Contacts

Jurisdiction	CCO Name	CCO Phone #	CCO Fax#/ Referral Email
Allegany	Potomac Community Services <i>(formerly PCMS)</i>	301-791-3087	301-393-0730
Anne Arundel	Center for Children	301-609-9887	301-609-7284
Baltimore City	Empowering Minds Resource Center	410-625-5088	410-625-4890
	Hope Health Systems	410-265-8737	410-265-1258 ccoreferral@hopehealthsystems.com
	Optimum Maryland	410-233-6200	410-233-6201
	Volunteers of America	240-579-6698	301-560-8505
	Wraparound Maryland	443-449-7713	443-451-8268
Baltimore County	Hope Health Systems	410-265-8737	410-265-1258 ccoreferral@hopehealthsystems.com
	Wraparound Maryland	443-449-7713	443-451-8268
Calvert	Center for Children	410-535-3047	410-535-3890
Caroline	Wraparound Maryland	410-690-4805	410-690-4806
Carroll	Potomac Community Services <i>(formerly PCMS)</i>	301-791-3087	301-393-0730
Cecil	Advantage Psychiatric Services	410-686-3629 Ext. 409	410-780-7178
Charles	Center for Children	301-609-9887	301-609-7284
Dorchester	Wraparound Maryland	410-690-4805	410-690-4806
Frederick	Potomac Community Services <i>(formerly PCMS)</i>	301-791-3087	301-393-0730
Garrett	Burlington United Methodist Family Services	301-334-1285	301-334-0668
Harford	Empowering Minds Resource Center	443-484-2306	443-484-2970
Howard	Center for Children	301-609-9887	301-609-7284 CCOferralsHOWARD@center-for-children.org
Kent	Wraparound Maryland	410-690-4805	410-690-4806
Montgomery	Volunteers of America	240-696-1565	301-306-5105
Prince George's	Center for Children	301-609-9887	301-609-7284
Queen Anne's	Wraparound Maryland	410-690-4805	410-690-4806
St. Mary's	Center for Children	301-475-8860	301-475-3843
Somerset	Wraparound Maryland	410-219-5070	410-219-5072
Talbot	Wraparound Maryland	410-690-4805	410-690-4806
Washington	Potomac Community Services <i>(formerly PCMS)</i>	301-791-3087	301-393-0730
Wicomico	Wraparound Maryland	410-219-5070	410-219-5072
Worcester	Wraparound Maryland	410-219-5070	410-219-5072

Should you require additional assistance or need information or clarification about services in your jurisdiction, please contact your Local Behavioral Health Authority/Core Service Agency (LBHA/CSA). A full directory of LBHAs/CSAs is available at <https://mabha.org/getting-help/>.

last updated 12/04/2023