### **CME Intensive Customized Care Coordination** Date of Referral

### **Please complete and email to selected Care Management Entity (CME) below**

### Youth’s Name:       DOB:       Age:     Gender:

Race:       Primary Language       Insurance Carrier:       Medicaid # (if applicable)

Parent/Guardian’s Name:       County:       School Grade:

Home/Placement Address:       City:       Zip:

Family Phone #:       Another #       Email Address:

Additional Contacts: Name:       Relationship:       Phone:

**Referring Party:**

|  |  |  |
| --- | --- | --- |
|  [ ] Parent/Guardian  [ ] Inpatient Hospital  [ ] Residential Facility (PRTF) [ ] DJJ In Community [ ] DJJ Secure Facility |  [ ] DBHDD Core Provider [ ] Private Provider or Pediatrician [ ] Juvenile Court [ ] DFCS Family Preservation [ ] DFCS Custody (GA Families 360) |  [ ] System of Care (LIPT/CHINS/CSEC)  [ ] School System [ ] Crisis Stabilization Unit (CSU) [ ] Family Support Organization [ ] Other:       |

|  |
| --- |
| DJJ Use Only: Juvenile ID       If DJJ Secure Facility, name of facility      DFCS/DJJ Use Only: Amerigroup Care Coordinator (Name & Contact Information)        |

Name of Person Referring:       Email:       Phone:

**Other Agencies Currently Involved:**

|  |  |  |
| --- | --- | --- |
|  [x] Enrolled in School (check if YES) [ ] Inpatient Hospital  [ ] PRTF (Residential Facility) [ ] Child Caring Inst. (Group Home) [ ] Dept. of Juvenile Justice  |  [ ] DBHDD Core Provider [ ] Private Provider or Pediatrician [ ] Juvenile Court  [ ] DFCS (non-custody only) [ ] DFCS Custody (GA Families 360) |  [ ] Family Support Organization  [ ] Law Enforcement  [ ] Crisis Stabilization Unit [ ] Georgia Cares (CSEC) [ ] Other:       |

School Attending:       Special School Services:       [ ]  IEP

Mental Health Diagnosis (Axis 1 Primary):       Mental Health Diagnosis (Axis 1 Secondary):

Substance Abuse Diagnosis       CAFAS score (≤ 6 mos.):       CANS? [ ] Yes [x] No If Y, please include copy of CANS

Please provide a brief youth and family history:       Medication(s):

**Presenting Problems:** Please select all applicable crisis and emergent needs:

[ ]  Self-harm [ ]  Sexual Offense [ ]  Fire Setting/Property Destruction [ ]  Runaway [ ]  Threats of Violence

[ ]  Active Substance Use [ ]  Behavioral Problems at School [ ]  Imminent Risk of Out-of-Home Placement [ ]  Other

**Please select any of the following services the youth has received in the past 6 months:**

|  |  |  |
| --- | --- | --- |
|  [ ] Inpatient Hospital  # of Inpatient Admissions       [ ] Residential Treatment Facility # of PRTF Admissions       [ ] Child Caring Institute (CCI) |  [ ] DJJ [ ] DFCS [ ] Juvenile Court [ ] Regional Youth Detention Center # of Stays       |  [ ] Youth Development Center  [ ] Crisis Stabilization Unit # of CSU Admissions     [ ] Other:       |

Has youth/family been presented at LIPT? [ ] Yes [ ] No If Yes, LIPT recommendation:

Has youth/family been presented at CHINS? [ ] Yes [ ] No If Yes, CHINS recommendation:

**Describe Challenges**:

**Please select which CME you’re referring to and email accordingly:**

 [x]  View Point Health Youth Services familywrap@vphealth.org

 [ ]  Lookout Mountain Care Management Entity lmcme@lmcs.org

**We will review your referral and contact you in three business days to discuss next steps. Thank you.**