### **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:**

|  |  |  |
| --- | --- | --- |
| 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 No If Y, please include copy of CANS

Please provide a brief youth and family history:       Medication(s):        
  
What are the youth’s strengths?       What are the family’s strengths?

**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:**

View Point Health Youth Services [familywrap@vphealth.org](mailto:familywrap@vphealth.org)

Lookout Mountain Care Management Entity [lmcme@lmcs.org](mailto:lmcme@lmcs.org)

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