Intensive Care Coordination Referral Form

(A Community Based Program)

Please fax referral to 855-277-4228

Referral Source Information	**Referral Date:**
Contact Name:	
Agency/Relationship:	
Phone #'s:	
Email:	

Child Information	
Child's Name (First, Middle, Last):	
Other Names (if applicable):	
Health Insurance Carrier:	**Insurance #:**
LINK Person ID # (If applicable):	
DCF Status: ☐ In Home Child Welfare ☐ Out of Home Committed ☐ Voluntary Services ☐ Juvenile Justice ☐ Dually Committed ☐ Family with Service Needs	

Address: _____

City: _____ **State:** _____ **Zip:** _____ **Country:** _____

Date of Birth: _____ **Gender:** ☐ Male ☐ Female ☐ Other

Race: ☐ White☐ Black or African American ☐American Indian or Alaska Native ☐ Asian Indian ☐ Japanese ☐ Native Hawaiian ☐ Chinese ☐ Korean ☐Guamanian or Chamorro ☐Filipino ☐ Vietnamese ☐ Samoan ☐ Other Asian ☐ Other Pacific Islander ☐ Some Other Race

Primary Language: _____

Has the youth been informed of this referral?: ☐ Yes ☐ No

Current Living Situation (Select one) : ☐ Home ☐ Foster Home ☐ Group Home ☐ Residential ☐ Other (Please Specify)**:** _____

Facility Name, if applicable: _____ **Phone #:** _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Facility Contact: _____ **Phone #:** _____
Admission Date to Facility: _____***Anticipated Discharge Date:** _____

Best practice for referrals is within 30 days of the "Anticipated Discharge Date" from the facility.

Parent/Legal Guardian Information	
Parent/Legal Guardian Name:	
Other Names (if applicable):	
Health Insurance Carrier:	**Insurance #:**
Relationship To Child:	**LINK Person ID # (If applicable):**

Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Home Phone: _____ Work Phone: _____

Date of Birth: _____

Race: ☐ White☐ Black or African American ☐American Indian or Alaska Native ☐ Asian Indian ☐ Japanese ☐ Native Hawaiian ☐ Chinese ☐ Korean ☐Guamanian or Chamorro ☐Filipino ☐ Vietnamese ☐ Samoan ☐ Other Asian ☐ Other Pacific Islander ☐ Some Other Race

Primary Language: _____

Has the parent/guardian been informed of this referral?: ☐ Yes ☐ No

Reason for Referral (Please include any additional materials which will help provide a comprehensive history of the youth and family, i.e. CANS, Case Plan, Treatment Plans...etc.):

_____
_____
_____
_____
_____
_____
_____

Current Providers involved with the family (please list below any referrals made):

Name	Role	Agency	Contact

List of Referrals Made: