carelon Behavioral Health

# 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:**