

## **Cumberland County LME Referral for Approval of CTSP funds for Intensive Services/Residential Treatment**

Dear Providers:

In order for Cumberland County LME/Community Collaborative to consider authorizing state funds for Residential Treatment and other intensive services, a referral, screening and prioritization must take place at the LME level. The Packet attached to this letter should be completed and submitted to the local community collaborative for review.

Referral packets should be completed by the Child and Family Team and reviewed by the Community Collaborative. A decision will be made with regards to the authorization of state funds to pay for the services. The Chairperson of the Collaborative and the LME Director (or the Director's designee) **must** sign in the appropriate space at the bottom of the page for the services to be authorized.

Thank you.

### **Authorization of Referral**

Approved By Director (or designee): \_\_\_\_\_

Date: \_\_\_\_\_

This referral has been reviewed and approved by:

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Community Collaborative Chairperson      Date

Cumberland County LME Referral for Intensive Services Approval

LME Record Number: \_\_\_\_\_

Date of Application: \_\_\_\_\_

Client's Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Dear \_\_\_\_\_:

The above named individual has been recommended for intensive services using state child mental health funds. Information that supports this referral is enclosed. It includes the following:

**MANDATORY INFORMATION (items with an\* must either accompany referral or be available for review if needed by the Community Collaborative. If not, this can delay review of the application.)**

- \_\_\_\_\_ \* Consent to Exchange Information Form
- \_\_\_\_\_ \* Placement Committee Referral Form\*
- \_\_\_\_\_ \* A detailed Psychosocial Assessment
- \_\_\_\_\_ \* Psycho-educational Testing: IQ and Achievement testing if available
- \_\_\_\_\_ \* For Developmentally Disabled Children (IQ under 70), a Vineland or other adaptive Behavior scale\*
- \_\_\_\_\_ Older psychological tests are also very helpful as well as recent Achievement Tests.
- \_\_\_\_\_ \* School Records (including grades and transcripts)\*
- \_\_\_\_\_ \* Special Education Services
- \_\_\_\_\_ \* Clinical Evaluation/Diagnostic Assessment
- \_\_\_\_\_ \* Person Centered Plan
- \_\_\_\_\_ Psychiatric Assessment (if available)\*
- \_\_\_\_\_ \* Discharge Summaries from Psychiatric Hospitalizations (if applicable)\*
- \_\_\_\_\_ \* Discharge Summaries from Prior Treatment Facilities\*
- \_\_\_\_\_ \* DSS Reports (if applicable)\*
- \_\_\_\_\_ Juvenile Court Reports (if applicable)
- \_\_\_\_\_ Neurological Testing (if applicable)
- \_\_\_\_\_ Speech/Language Evaluation (if applicable)
- \_\_\_\_\_ Immunization Records
- \_\_\_\_\_ Staffing Notes from the Child and Family Team meeting
- \_\_\_\_\_ Other \_\_\_\_\_
- \_\_\_\_\_ Other \_\_\_\_\_

If you have any questions about this referral, please call me at \_\_\_\_\_,

My e-mail address is: \_\_\_\_\_ . FAX # is \_\_\_\_\_.

Please direct all hard copy mail to:      Attention: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Sincerely,

Referring Therapist/Case Manager: \_\_\_\_\_

1. **IDENTIFYING INFORMATION**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Sex: \_\_\_\_\_

County of Residence: \_\_\_\_\_

Referring Person: \_\_\_\_\_

Referring Clinical Home Staff: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Other Agency Workers On Team (D.S.S./D.J.J etc): \_\_\_\_\_

Address: \_\_\_\_\_

Phone/Fax: \_\_\_\_\_

Address: \_\_\_\_\_

Phone/Fax: \_\_\_\_\_

**CURRENT STATUS**

Legal Guardian: \_\_\_\_\_

Current Residence: \_\_\_\_\_

Legal Status/Juvenile Court Involvement (Prior and/or current): \_\_\_\_\_

Current Educational Placement/Exceptionality/Grade Level: \_\_\_\_\_

List and describe interventions/placements previously tried and which aspects were successful/unsuccessful (include out-patient treatment, residential, hospitalization, etc.)

Treatment Intervention/Placement	Dates	Client Response


3. **DIAGNOSTIC INFORMATION**

**DSM IV-TR Diagnoses/Date of Diagnosis:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Previous DSM-IV Diagnoses of Concern:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Primary Symptoms/Behaviors (check all that apply)**

	<b>Yes</b>	<b>No</b>	<b>Unknown</b>	<b>If yes, describe</b>
Psychotic				
Assaultive				
Destructive				
Suicidal				
Self-Destructive				

Runaway Tendencies				
Sexual Acting Out				
Substance Abuse				
Other (Anti-social or conduct problems including any gang involvement if applicable)				
Other				

**Strengths/Assets** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**IQ (FSIQ, Verbal, and Performance)/Level of Functioning Assessments/Dates of Testing (If IQ is below 70, Vineland or other adaptive behavior scales are needed):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medical/Health Problems:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Current Medications:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Substance Use /Abuse History:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Sexual Offense/Abuse History:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**4. ECOLOGICAL INFORMATION**

**NOTE: Family involvement in treatment services is critical for consideration of out of home placement, including Level I, II, III, IV and PRTF services.**

**Plan/Identification/Description of Visiting Resource:** \_\_\_\_\_

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**Plans for transportation to and from Visiting Resource:** \_\_\_\_\_

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**After Care Plan—Identify Specific Placement and Support Services To Be Provided:** \_\_\_\_\_

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**Parental/Family Involvement:**

**Does this child have a family permanently committed to him/her? Yes\_\_\_\_\_ No\_\_\_\_\_**

**If "yes", how will this child's family be involved in treatment during placement?**

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**If "no", who will represent this child in the role of surrogate parent?**

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**Are there other advocates who can or should be involved in the Child & Family Team process?**

**If so, please identify names and contact information**\_\_\_\_\_

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**For Residential Treatment requests, behaviors or conditions that make continued placement in the home difficult.**

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**5. TREATMENT ISSUES**

**Why are you referring?** \_\_\_\_\_

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**List questions that need to be answered for the child to be successfully maintained in the community?** \_\_\_\_\_

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**What services will the clinical home provide while client is in Placement, if the referral is for residential treatment?** \_\_\_\_\_

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**Signature:** \_\_\_\_\_  
**Person Making Referral**

**Date:** \_\_\_\_\_