

**Service Coordination Referral for
Allegheny County Provider
Child / Adolescent**

Consumer Name:		Date of Referral:	
DOB:	SSN:	Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Race/Ethnicity:	Primary Language:	Grade: School: Special Ed. (If so, what level?):	
Current Address:			
Phone Number:		Best time to call:	
Financial Information/Source of Income			
Monthly Income Amount:	<input type="checkbox"/> Employment	<input type="checkbox"/> SSI	<input type="checkbox"/> SSDI <input type="checkbox"/> Public Assistance
If applied for and not yet receiving potential source of income, please describe and give date of application:			
Do you currently have a Representative Payee:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Please Provide Name and contact Information:	
Health Insurance Information			
Medical Assistance:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare:	<input type="checkbox"/> Yes <input type="checkbox"/> No Other: (please describe)
Emergency Contact Information (Include Family, Educational / Medical Guardian, CYF Caseworker, and/or JPO)			
Name:		Relationship:	
Address:			
Phone Number:			
Name:		Relationship:	
Address:			
Phone Number:			
Name:		Relationship:	
Address:			
Phone:			
Does child have a guardian (i.e. medical / educational guardian, guardian ad litem, permanent legal custodian):		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, Please provide Name and contact information:			
Referral Source			
Person making Referral (Name and Title):			
Representing which Agency/committee:			
Address:			
Phone:		Fax:	Email:
Relationship to Consumer:			
Is Service Participant in Agreement with Referral:		<input type="checkbox"/> Yes <input type="checkbox"/> No (If no please explain)	

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Mental Health Information

DSM IV Diagnosis

Diagnosed by:	Date:
Axis I:	
Axis II:	
Axis III (Medical Condition/problem):	
Axis IV (Stresses):	
Axis V: GAF Current	GAF Highest level in past 12 months
Please attach a recent Psych Eval or Doctor's Signature to verify Diagnosis	

Risk Factors: (Explain Below as necessary)	Unknown	Yes	No
Suicidal (Ideation, Attempt)			
Homicidal (Ideation, Attempt)			
Aggression / Physical Harm to Others			
Victimization of Others			
Destruction of Property			
Fire Setting			
Sexual Acting Out (Specify as abusive or sexually reactive behaviors)			
Impulsivity			
Reckless Behavior possibly leading to physical harm to self or others			
School Refusal			
Unavailable Caretaker			
Other: (Explain)			

Reason for Referral – Please indicate how Service Participant could benefit from Service Coordination:

Eligibility Criteria

I. Diagnosis (Diagnosis of Schizophrenia or Mood Disorder or any other Axis I diagnosis in the DSM IV excluding MR or Psychoactive Substance Abuse, Organic Brain Syndrome or V Code):

II Treatment History: Must have one of the following

- At risk for out-of-home placement without services**
- Returning from community inpatient or other out-of-home placement**
Provide Dates:
- Age 6 yrs. or younger and require or enrolled in Early Intervention Services**
Provide Dates:
- Receiving, with their family, services from 3 or more publicly funded programs**
- Recommended as needing MH Services by local interagency team**
- Transfer from another Blended Service Coordination Provider**

III. GAF (must have a GAF of 60 or Below)

Referral Source Signature/Date:

Service Participant Signature/Date:

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