90-Day Suitability Assessment - Referral Form

Revised: February 1, 2019

Child Information		
NAME:	**MEDICAID NUMBER:**	**SOCIAL SECURITY NUMBER:**
DATE OF BIRTH:	**GENDER:** ☐ Male ☐ Female	
COUNTY OF ORIGIN:	**CIRCUIT:**	**AREA:**
CURRENT MEDICATIONS:		

Single Point of Access (SPOA) Contact Information		
NAME:	**PHONE NUMBER:**	**EMAIL:**

CURRENT MENTAL HEALTH ISSUES, TREATMENT PROGRESS

DESIRED TREATMENT OUTCOME

SUMMARY OF PERMANENCY PLAN GOALS, INCLUDING PLANNED DISCHARGE PLACEMENT

CURRENT DSM-5 DIAGNOSIS	

Prescribing Physician	
NAME:	**PHONE NUMBER:**

Child's Current Living Arrangement			
NAME OF CURRENT LOCATION/PLACEMENT:			
PLACEMENT TYPE: ☐ In-Patient ☐ STGH ☐ Shelter ☐ Detention Center ☐ CSU ☐ Foster Home ☐ Relative ☐ Other:			
DAYTIME PHONE NUMBER:	**EVENING PHONE NUMBER:**		
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
Community Based Care Caseworker			
NAME:	**PHONE NUMBER:**	**EMAIL ADDRESS:**	
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
Guardian ad litem			
NAME:		**EMAIL ADDRESS:**	
PHONE NUMBER:	**FAX NUMBER:**		
Attorney Ad Litem			
NAME:		**EMAIL ADDRESS:**	
PHONE NUMBER:	**FAX NUMBER:**		

CHECKLIST OF REQUIRED DOCUMENTS (MENTAL HEALTH MUST BE MARKED). THIS SECTION MUST BE FILLED OUT TO PROCESS THE REFERRAL.
☐ COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT
☐ MENTAL HEALTH TREATMENT HISTORY, CURRENT
☐ COURT INFORMATION: ☐ SHELTER PETITION, ☐ SHELTER ORDER, ☐ JUDICIAL REVIEW, ☐ CASE PLAN
☐ EVALUATIONS: ☐ PSYCHOLOGICAL, ☐ PSYCHIATRIC, PSYCHOSOCIAL, ☐ PSYCHOSEXUAL EVALUATIONS
☐ TREATMENT PROVIDER DOCUMENTATION: ☐ TREATMENT PLAN, ☐ COUNSELING/MEDICATION MANAGEMENT/ABA
☐ DELINQUENCY INFORMATION (DJJ, JDC, PROBATION, ETC.)
☐ MULTIDISCIPLINARY TEAM (MDT) MEETING NOTE (FOR A CHILD NOT CURRENTLY PLACED IN RESIDENTIAL TREATMENT)

We believe that _____, a child in the custody of the Department of Children and Families/CBC, is emotionally disturbed and may need residential treatment, pursuant to Section 39.407, Florida Statute.

I certify the referral form and package are complete and that all information will be provided to the Qualified Evaluator upon assignment.

SIGNATURE OF SPOA **DATE**

Note: Referral Cannot Be Processed if Information Submitted is Illegible or Incomplete.

Magellan Medicaid Administration, Inc.
To transmit request information:
Fax: 1-888-656-6823
Phone: 1-800-562-4059