**C.A.R.E. NETWORK**

**(Consumer Advocate, Resiliency, and Empowerment Network)**

**Referral For Mental Health & Substance Abuse Services**

**CONSUMER INFORMATION**

|  |
| --- |
| **Name of Consumer**  |
| **Date of Birth** | **Male or Female** | **Race** | **Medicaid ID#** | **Social Security #** | **Current School & Grade** | **Active IEP?****Attach Copy** |
|  |  |  |  |  | **Grade:** | **Yes / No** |
| **School:** |
| **Parent/Guardian (if consumer is a minor) (print clearly)** | **Address: (**Street / City / State / Zip) |
| **Daytime Phone #:** |
| **Evening Phone #:** | **Cell Phone #:** |

**PLEASE COMPLETE IF CONSUMER HAS A CURRENT DSM-IV DIAGNOSIS:**

|  |
| --- |
| **CURRENT MEDICATIONS AND DOSAGES:** |
| **NAME OF PRESCRIBING PHYSICIAN:** | **PHYSICIAN’S CONTACT #:** |
| **NAME OF DIAGNOSING PROFESSIONAL:** | **PROFESSIONAL’S CONTACT #:** |
| **THE FOLLOWING TO BE COMPLETED BY C.A.R.E. NETWORK** |
| **AXIS I** |
| **AXIS II** |
| **AXIS III** |
| **AXIS IV** |
| **AXIS V - GAF:**  |

**FAMILY FINANCIAL INFORMATION**

**Complete all sections; place N/A or $0 for items that are not applicable. Verification may be needed in the future.**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **NAME** | **MEDICAID****ID #** | **Insurance Provider Name & Policy #** | **SSI**  | **AFDC** | **CHILD Support**  | **Adoption Subsidy** | **FOOD STAMPS** | **EARNINGS** |
|  |  |  | $ | $ | $ | $ | $ | $ |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |  |  |
| **TOTAL GROSS MONTHLY INCOME** | **$**  |

**DEPT OF CORRECTIONS AND/OR JUVENILE JUSTICE PROBATION OFFICER:**

|  |
| --- |
| **CONSUMER’S NAME**: |
| Probation Officer’s Name: | Mailing address: |
| Phone #: |  |
| Pager or cell phone #: |  |
| Email address:  |  |

**SUMMARY OF CONSUMER’S LEGAL INVOLVEMENT:**

|  |
| --- |
| ***List any arrests, charges, and problems the consumer has had in his/her life. Also list the actions taken be the law enforcement officials (arrested, sent to detention, community control, placement, etc).*** |
|  |

**REASON FOR REFERRAL FOR TREATMENT:**

|  |
| --- |
| ***Check the general service that you are requesting (more than 1 if needed). Then, in your own words, indicate the need(s) that the family currently has for services. Such programs are for consumers who meet specific guidelines due to their significant emotional, mental health, and substance abuse needs.***  |
|  **🞎 Behavioral Health Services 🞎 Case Management 🞎 Residential Treatment** |
|  |
|  |
|  |
|  |
|  |

**DESIRED OUTCOMES OF TREATMENT:**

|  |
| --- |
| ***In your own words, describe what outcomes you want for the family due to the services requested.*** |
|  |
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|  |

**ADDITIONAL COMMENTS OR INFORMATION REGARDING THIS REFERRAL:**

|  |
| --- |
|  |

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| **PLEASE COMPLETE THIS ENTIRE FORM ALONG WITH ATTACHMENTS** **A, B, AND RETURN TO THE CARE NETWORK COORDINATOR** |
| **Parent or Guardian’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Signature of CARE Network Member:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referral accepted by CARE Network on:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (DATE)

 **ATTACHMENT A**

Please complete one per consumer, make additional copies of this form if needed and attach)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Within Last Three Months** | **Within Last Six Months** | **Within The** **Last Year** | **Over One Year Ago** | **RISK INDICATORS**Check ALL data columns and factors that apply |
| 🔿 | 🔿 | 🔿 | 🔿 | 1. **Victim of Physical Abuse (🔿 confirmed, 🔿 alleged)**
 |
| 🔿 | 🔿 | 🔿 | 🔿 | 1. **Victim of Sexual Abuse**
 |
| 🔿 | 🔿 | 🔿 | 🔿 | 1. **Perpetrator of Sexual Abuse**
 |
| 🔿 | 🔿 | 🔿 | 🔿 | 1. **Victim of Emotional Abuse**
 |
| 🔿 | 🔿 | 🔿 | 🔿 | 1. **Victim of Neglect**
 |
| 🔿 | 🔿 | 🔿 | 🔿 | 1. **Verbally Threatens Suicide**
 |
| 🔿 | 🔿 | 🔿 | 🔿 | 1. **Suicidal Gestures**
 |
| 🔿 | 🔿 | 🔿 | 🔿 | 1. **Actual Suicide Attempt(s)**
 |
| 🔿 | 🔿 | 🔿 | 🔿 | 1. **Hurt Someone**
 |
| 🔿 | 🔿 | 🔿 | 🔿 | 1. **Threatened to Hurt**
 |
| 🔿 | 🔿 | 🔿 | 🔿 | 1. **Self Injurious Behavior**
 |
| 🔿 | 🔿 | 🔿 | 🔿 | 1. **Significant School Problems:**

 **🔿 Failure 🔿 Truancy 🔿 Suspension 🔿 Behavior 🔿 Other: \_\_\_\_\_\_\_\_** |
| 🔿 | 🔿 | 🔿 | 🔿 | 1. **Frequent Unmanageable Behavior**
 |
| 🔿 | 🔿 | 🔿 | 🔿 | 1. **Noncompliant Behavior**
 |
| 🔿 | 🔿 | 🔿 | 🔿 | 1. **Run Away**
 |
| 🔿 | 🔿 | 🔿 | 🔿 | 1. **Age/Socially Inappropriate Sexual Behavior**
 |
| 🔿 | 🔿 | 🔿 | 🔿 | 1. **Damaged Property**
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| 🔿 | 🔿 | 🔿 | 🔿 | 1. **Stole Property**
 |
| 🔿 | 🔿 | 🔿 | 🔿 | 1. **Avoids Social Contact**
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| 🔿 | 🔿 | 🔿 | 🔿 | 1. **Frequently moved for poor behavior**
 |
| 🔿 | 🔿 | 🔿 | 🔿 | 1. **Frequently Anxious**
 |
| 🔿 | 🔿 | 🔿 | 🔿 | 1. **Frequent Nightmares**
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| 🔿 | 🔿 | 🔿 | 🔿 | 1. **Fire Setting**
 |
| 🔿 | 🔿 | 🔿 | 🔿 | 1. **Cruelty to Animals**
 |
| 🔿 | 🔿 | 🔿 | 🔿 | 1. **Frequent Bed Wetting**
 |
| 🔿 | 🔿 | 🔿 | 🔿 | 1. **Chronic Eating Disorder**
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| 🔿 | 🔿 | 🔿 | 🔿 | 1. **Pregnancy**
 |
| 🔿 | 🔿 | 🔿 | 🔿 | 1. **Abandonment**
 |
| 🔿 | 🔿 | 🔿 | 🔿 | 1. **Used Drugs or Alcohol**
 |
| 🔿 | 🔿 | 🔿 | 🔿 | 1. **Others (describe):**
 |
| 🔿 | 🔿 | 🔿 | 🔿 | **None Known** |

**ATTACHMENT B**

**CONSENT TO STAFFING**

By signing below my child or self, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , and I/we (if applicable) are consenting to his/her or my referral to the Consumer Advocacy, Resiliency, and Empowerment (C.A.R.E.) Network.

It has been explained to us that the purpose of this referral is to help us design and arrange for services which will help us resolve emotional, mental health, and/or substance abuse problems that my child, myself, and/or my family is experiencing. In addition, we understand that if we are referred for services, the C.A.R.E. Network will periodically assist us in monitoring progress. I/we understand that the C.A.R.E. Network financial resources are limited and as a result, the services needed may be financially inaccessible.

It has also been explained to us that we have the right to receive notice of any meetings in which decisions about our request for assistance will be made and that we have the right to participate in decision making about services for us.

As \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ parents(s)/legal guardian (if applicable) or self, by my/our signatures below, I/we agree to participate in treatment recommended and agree to participate in the payment for treatment to the extent I/we are able. It has been explained to me/us that I/we have the right to withdraw this consent at any time and also that I/we may refuse to participate or refuse to consent to my/our child’s participation in any treatment recommended.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Consumer Signature Print Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Parent or Guardian Signature (if consumer is a minor) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Witness Signature Date