Initial 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:		
DATE OF MULTIDISCIPLINARY TEAM (MDT) MEETING:		

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

Diagnosis	
DSM-5:	

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:

REASON FOR REFERRAL FOR RESIDENTIAL TREATMENT (DETAILED MENTAL HEALTH INFORMATION REQUIRED IN THIS SECTION)

DESIRED OUTCOMES OF RESIDENTIAL TREATMENT

SUMMARY OF PERMANENCY PLAN GOALS FOR THE CHILD, INCLUDING PLANNED DISCHARGE PLACEMENT

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

CHECKLIST OF REQUIRED DOCUMENTS (MENTAL HEALTH MUST BE MARKED). THIS SECTION MUST BE FILLED OUT TO PROCESS THE REFERRAL.
☐ COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT
☐ MULTIDISCIPLINARY TEAM (MDT) MEETING NOTE (NOT REQUIRED IF REFERRAL IS COURT ORDERED)
☐ MENTAL HEALTH TREATMENT HISTORY, FOR AT LEAST THE LAST 12 MONTHS
☐ COURT INFORMATION: ☐ SHELTER PETITION, ☐ SHELTER ORDER, ☐ JUDICIAL REVIEW, ☐ CASE PLAN
☐ INDIVIDUAL EDUCATION PLAN
☐ EVALUATIONS: ☐ PSYCHOLOGICAL, ☐ PSYCHIATRIC, PSYCHOSOCIAL, ☐ PSYCHOSEXUAL EVALUATIONS
☐ PROVIDER CLINICAL NOTES, ☐ COUNSELING/MEDICATION MANAGEMENT/ABA
☐ DELINQUENCY INFORMATION (DJJ, JDC, PROBATION, ETC.)
☐ OTHER (PLEASE SPECIFY):

ADDITIONAL COMMENTS OR INFORMATION

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.

SIGNATURE OF COMMUNITY BASED CASE WORKER **DATE**

SIGNATURE OF COMMUNITY BASED SUPERVISOR **DATE**

SIGNATURE OF COMMUNITY BASED DIRECTOR **DATE**

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**

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