CME Intensive Customized Care Coordination

Date of Referral _____

Please complete and email to selected Care Management Entity (CME) below

Youth's Name: _____ DOB: _____ Age: ___ Gender: _____

Race: _____ Primary Language _____ Insurance Carrier: _____ Medicaid # (if applicable) _____

Parent/Guardian's Name: _____ County: _____ School Grade: _____

Home/Placement Address: _____ City: _____ Zip:_____

Family Phone #: _____ Another # _____ Email Address: _____

Additional Contacts: Name: _____ Relationship: _____ Phone: _____

Referring Party:

☐ Parent/Guardian	☐ DBHDD Core Provider	☐ System of Care (LIPT/CHINS/CSEC)
☐ Inpatient Hospital	☐ Private Provider or Pediatrician	☐ School System
☐ Residential Facility (PRTF)	☐ Juvenile Court	☐ Crisis Stabilization Unit (CSU)
☐ DJJ In Community	☐ DFCS Family Preservation	☐ Family Support Organization
☐ DJJ Secure Facility	☐ DFCS Custody (GA Families 360)	☐ Other: _____

DJJ Use Only: Juvenile ID _____ If DJJ Secure Facility, name of facility _____

DFCS/DJJ Use Only: Amerigroup Care Coordinator (Name & Contact Information) _____

Name of Person Referring: _____ Email: _____ Phone: _____

Other Agencies Currently Involved:

☒ Enrolled in School (check if YES)	☐ DBHDD Core Provider	☐ Family Support Organization
☐ Inpatient Hospital	☐ Private Provider or Pediatrician	☐ Law Enforcement
☐ PRTF (Residential Facility)	☐ Juvenile Court	☐ Crisis Stabilization Unit
☐ Child Caring Inst. (Group Home)	☐ DFCS (non-custody only)	☐ Georgia Cares (CSEC)
☐ Dept. of Juvenile Justice	☐ DFCS Custody (GA Families 360)	☐ Other: _____

School Attending: _____ Special School Services: _____ ☐ IEP

Mental Health Diagnosis (Axis 1 Primary): _____ Mental Health Diagnosis (Axis 1 Secondary): _____

Substance Abuse Diagnosis _____ CAFAS score (≤ 6 mos.): _____ CANS? ☐ Yes ☒ No If Y, please include copy of CANS

Please provide a brief youth and family history: _____ Medication(s): _____

Presenting Problems: Please select all applicable crisis and emergent needs:

☐ Self-harm ☐ Sexual Offense ☐ Fire Setting/Property Destruction ☐ Runaway ☐ Threats of Violence
☐ Active Substance Use ☐ Behavioral Problems at School ☐ Imminent Risk of Out-of-Home Placement ☐ Other_____

Please select any of the following services the youth has received in the past 6 months:

☐ Inpatient Hospital # of Inpatient Admissions _____	☐ DJJ	☐ Youth Development Center
☐ Residential Treatment Facility # of PRTF Admissions _____	☐ DFCS	☐ Crisis Stabilization Unit # of CSU Admissions ___
☐ Child Caring Institute (CCI)	☐ Juvenile Court	☐ Other: _____
	☐ Regional Youth Detention Center # of Stays _____	

Has youth/family been presented at LIPT? ☐ Yes ☐ No If Yes, LIPT recommendation: _____

Has youth/family been presented at CHINS? ☐ Yes ☐ No If Yes, CHINS recommendation: _____

Describe Challenges: _____

Please select which CME you're referring to and email accordingly:

☒	View Point Health Youth Services	familywrap@vphealth.org
☐	Lookout Mountain Care Management Entity	lmcme@lmcs.org

We will review your referral and contact you in three business days to discuss next steps. Thank you.