Metro Crisis Coordination Program – Intake/Referral Form

All sections must be completed in order for a referral to be processed

Client Information:

Todays Date:_____

Name_____

Date of Birth _____

Social Security #_____

Gender _____

Address_____

City_____

State_____

Zip_____

Phone Number_____

County of Residence_____

Referral Information:

Type of Service: *(check one)*

Technical Assistance *(case will be assigned to a behavior analyst to do an assessment)* **_____**

Crisis/Temporary Care bed placement *(case will be assigned to a crisis placement worker)* **_____**

BOTH technical assistance & crisis/temporary care bed placement _____

Referral Status:

First time _____ Reactivation _____

Funding Source: *(check one)*

MA regular waiver _____, MA only _____ will they be screened onto the waiver (yes)____, (no)_____

ICFMR____, CSG ____, FSG____, CDCS____ *(Has the guardian agreed to the cost to their budget ? yes___, no___)* **, CADI____, TEFRA____.**

No funding _____

Reason for Referral:

Provide a description of the clients' symptoms, events, and/or environmental situation/s that have led to this referral request.

Greatest Risks: (*check all that apply)*

Risk of Loss of Placement ___, Breaks the Law _____, Eats Non-Nutritive Substances_____, Elopes ____,

Inappropriate Sexual Behavior ____, Injurious to Self _____, Physical Aggression ____, Property Destruction_____,

Verbal/Gestural Aggression_____, OTHER _____

COMMENTS: _____

DIAGNOSIS INFORMATION:

IDD level: (please check)

Borderline_____, Mild_____, Moderate_____, Severe_____, Profound_____, Related Condition_____,

ID/DD Diagnosis YES_____ NO_____

Allergies: (list all that apply)_____

Level of ADL's : Independent _____, Needs Assistance _____, Needs Prompts _____

Communication level: Limited_____, Not Verbal _____, Verbal _____

Psychiatric Diagnosis: _____

_____

Medical Diagnosis: _____

_____

_____

Misc. Info:	YES	or	NO	(please check the following)
Client had Previous Psychiatric Hospitalization	☐		☐	
Has a Behavior Support Plan	☐		☐	
Has a Positive Support Transition Plan	☐		☐	
Is taking Psychotropic Medication	☐		☐	
Has an Individual Abuse Prevention Plan	☐		☐	

LIST ALL CURRENT MEDICATIONS:_____

_____

_____

_____

SUPPORT TEAM CONTACT INFORMATION:

Guardian:

Name _____

Relationship_____

Day Phone _____

Evening Phone _____

Mobile Phone _____

Email address_____

Street Address_____

City_____

State_____

Zip Code_____

Guardians Legal status: Self ____ - A Private Guardian____ - State Appointed_____

Additional contacts/ info/comments:_____

Residential Supports:

Type of Residence: *(check one) Family Home____, Group Home_____, Foster Home_____, ICF_____, Own apartment/home_____*

Support Type:_____

Provider Company Name:_____

Primary Contact Person:_____/title_____ Phone #_____
FAX:_____

Email _____

Secondary Contact Person:_____ /title_____ Phone# _____

Email _____

COMMENTS:_____

CASE MANAGER:

County of Financial Responsibility _____

Name:_____

Address:_____

City_____

State_____

Zip_____

PHONE_____ FAX_____

EMAIL_____

EDUCATION or Day Supports:

School or Program name_____

Contact Name_____

Phone number_____

Mobile Phone_____

Email Address_____

Street Address_____

City_____

State_____

ZIP_____

Additional info_____

IF THE CLIENT IS CURRENTLY AT THE HOSPITAL:

Name of Hospital:_____

Primary Hospital Contact Person's name_____/title

Phone number_____

Admission date:_____

Additional info and/or Additional contacts at the hospital (please include name/title/phone number:

_____

_____

After this form is completed, please fax it along with the client's Individual Abuse Prevention Plan - or Health and Safety Plan, ISP - or similar case manager documentation to 612-869-6743 - Attention to: INTAKE

MCCP will process this intake and assign it to a Behavior Analyst who will make initial contact with team members.