

Metro Crisis Coordination Program – Intake/Referral Form

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

TODAY'S DATE

CLIENT INFORMATION

Name	<input type="text"/>	Gender	<input type="text"/>
Date of Birth	<input type="text"/>	Social Security Number	<input type="text"/>
Address	<input type="text"/>		
City	<input type="text"/>	Phone Number	<input type="text"/>
State	<input type="text"/>	Zip	<input type="text"/>
		County of Residence	<input type="text"/>

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):

- IDD Waiver
- ICFMR
- CSG
- FSG
- CADI
- TEFRA
- No funding
- MA only - Will they be screened onto the waiver? YES NO
- CDGS - Has the guardian agreed to the cost to their budget? YES NO

Reason for Referral:

Provide a description of the client's 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 Non Verbal Verbal Translator Needed English 2nd Language

Psychiatric Diagnosis:

Medical Diagnosis:

Misc. Info (please check the following):

- | | YES | NO |
|---|--------------------------|--------------------------|
| Client had Previous Psychiatric Hospitalization | <input type="checkbox"/> | <input type="checkbox"/> |
| Has a Behavior Support Plan | <input type="checkbox"/> | <input type="checkbox"/> |
| Has a Positive Support Transition Plan | <input type="checkbox"/> | <input type="checkbox"/> |
| Is taking Psychotropic Medication | <input type="checkbox"/> | <input type="checkbox"/> |
| Has an Individual Abuse Prevention Plan | <input type="checkbox"/> | <input type="checkbox"/> |

List All Current Medications:

SUPPORT TEAM CONTACT INFORMATION

Guardian:

Name	<input type="text"/>	Day Phone	<input type="text"/>
Relationship	<input type="text"/>	Evening Phone	<input type="text"/>
Email Address	<input type="text"/>	Mobile Phone	<input type="text"/>
Street Address	<input type="text"/>		
City	<input type="text"/>	Guardian's Legal Status:	
State	<input type="text"/>	<input type="checkbox"/> Self	<input type="checkbox"/> Private Guardian <input type="checkbox"/> 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	<input type="text"/>	Provider Company Name	<input type="text"/>		
Primary Contact	<input type="text"/>	Title	<input type="text"/>	Phone Number	<input type="text"/>
Email	<input type="text"/>			Fax	<input type="text"/>
Secondary Contact	<input type="text"/>	Title	<input type="text"/>	Phone Number	<input type="text"/>
Email	<input type="text"/>			Fax	<input type="text"/>

Comments:

CASE MANAGER

County of Financial Responsibility

Name

Address Phone Number

City Fax

State Zip Email

EDUCATION OR DAY SUPPORTS

School or Program Name

Contact Name Phone Number

Email Address Mobile Phone

Street Address Additional Info

City

State Zip

IF THE CLIENT IS CURRENTLY AT THE HOSPITAL

Name of Hospital Admission Date

Primary Hospital Contact Title

Phone Number

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.