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

Date of Birth

Address

City

State

Zip

Gender

Social Security Number

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)*:

- IDD Waiver
- ICFMR
- CSG
- FSG
- CADI
- TEFRA
- No funding
- MA only - *Will they be screened onto the waiver?* *YES* *NO*
- CDCS - *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		
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

Email Address

Day Phone

Evening Phone

Mobile Phone

Street Address

City

State

Zip

Guardian's Legal Status:

☐ Self ☐ 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

Title

Phone Number

Email

Fax

Secondary Contact

Title

Phone Number

Email

Fax

Comments:

CASE MANAGER

County of Financial Responsibility

Name

Address

City

State

Zip

Phone Number

Fax

Email

EDUCATION OR DAY SUPPORTS

School or Program Name

Contact Name

Email Address

Street Address

City

State

Zip

Phone Number

Mobile Phone

Additional Info

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.