# CONNECTICUT CARE COORDINATION REFERRAL FORM

Youth Name:
Date of Birth: Age:
Gender: ☐ Male ☐ Female
Residing Address: (include apt. # or floor#):

Parent/Guardian Name(s): Date of Birth:
Relationship to Youth:
# of other children in home: # of other adults in home:
Phone: (**list all possible phone #s)** (home)
(work) (cell)
*Best day and time to contact:
Email:

Hispanic Origin: ☐ Yes ☐ No
Race (check all that apply): ☐ Asian American ☐ Black ☐ White
☐ Other ☐ Native American ☐ Pacific Islander

**Preferred** Language – Parent/Guardian: Youth:

Youth & Family Strengths: (**Please explain what you know about the child/youth/family's hobbies, talents, skills, and interests):**

What does the youth and family consider to be their main challenges (including emotional and behavioral challenges) in the home, school, and/or community?

Provider Concerns (Behaviors, Recent Trauma, Relevant Family Medical Info):

What are the safety concerns for the youth and family:

Current Supports -- school, friends, neighbors, family (include 2ndary parent if applicable), providers, community, etc.:

| NAME: | ROLE/Relationship to: | PHONE : |
|---|---|---|
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Referral Source Name: Phone:
Relationship/Agency: Date of Referral:
Email:
Previous family involvement in Care Coordination or Family Advocacy:
☐ No ☐ Yes (if yes when/where?)

Current School:
Grade: Special Education: ☐ Yes ☐ No ☐ 504

Current DCF Involvement (for anyone in household): ☐ No ☐ Yes
Worker: Phone:

Current JJ/Probation Involvement: ☐ No ☐ Yes
Worker: Phone:

Current Clinical Diagnoses (**DSM 5 preferred**):

**"I understand that my signature gives the referring agency/person permission to share the above information with the Care Coordination Program and that this information will be used to determine eligibility for that program."**
**Parent/Guardian Signature: ________________________________________**
**Date: ________________**

**Parent/guardian approval is required for submission/acceptance of referral.**
If unable to obtain signature or submitting referral electronically please be sure to keep all protected health information (PHI) secure according to HIPPA and HITECH regulation:
☐ As the referring person/agent I have reviewed this referral with the parent/guardian and I have their permission to submit this referral for the Care Coordination program.

Recent or Pending Referrals for family (please list w/ contact info):

***Please note that this information is collected for reporting in the Provider Information Exchange System. Confidentiality and privacy will be carefully maintained, and data will only be used for general reporting as required by funding sources, progress monitoring and planning purposes.***