



## CCBH/FCSS INITIAL REFERRAL FORM

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Referral Source: \_\_\_\_\_

Child's DOB: \_\_\_\_\_

Referral Phone #: \_\_\_\_\_

Current Placement: \_\_\_\_\_

Custody Status: \_\_\_\_\_

Diagnosis (**MUST HAVE A MENTAL HEALTH AND/OR ALCOHOL OR DRUG RELATED DIAGNOSIS TO BE ELIGIBLE FOR CCBH or FCSS SERVICES**):

Is child Medicaid eligible?

Yes

No

Date of most recent Cluster: \_\_\_\_\_

Next scheduled Cluster date: \_\_\_\_\_

Systems child is involved with:

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- 
- 
- 

CPS  
JFS  
Board of Developmental Disabilities  
Juvenile Court

- 
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Mental Health  
Substance Abuse

Describe child's multi-needs:

Service being requested?

- Home Based Support (Pressley Ridge) - **FCSS**
- Respite Care (LYS OR SJO) - **FCSS**
- Virtual Residential Program (Camelot) - **CCBH**
- Monitor Prime (Camelot) - **CCBH**

Why are services being requested at this time?

**Please complete all information on this form. Incomplete referrals will not be considered.**

**Fax the completed form to: FCF - CCBH/FCSS Referral 732-5414**

