System of Care Referral and Eligibility Determination

System of Care Referral Form- Dallas and Madison County

A. CHILD'S DEMOGRAPHIC INFORMATION

Client's Name: _____ Date of Birth: _____

(First, Middle, Last)

Gender: _____ Pronouns: _____

Parent/Guardian Name _____

Home Address: _____ City: _____

County: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Preferred method of contact: _____

Insurance Coverage ☐ Hawk-I ☐ No Insurance ☐ Private Insurance

B. CHILD'S CURRENT LIVING SITUATION: For adults the child is currently living with please provide in the following information.

Name of Adult 1: _____ Name of Adult 2: _____

Relationship to Child: _____ Relationship to Child: _____

Phone: _____ Phone: _____

E-Mail Address: _____ E-Mail Address: _____

Preferred method of contact? _____ Preferred method of contact? _____

If child is <u>not</u> living with biological parent(s), please provide in the following information on biological parent(s).

Adult Name: _____ Adult Name: _____

Relationship to Child: _____ Relationship to Child: _____

Street Address: _____ Street Address: _____

City, State and Zip: _____ City, State and Zip: _____

Home Phone _____ Home Phone: _____

Cell Phone: _____ Cell Phone: _____

C. Current services being utilized

Name and type of provider	Agency	Phone Number(s)

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D. REFERRAL INFORMATION

Referred by: Work Phone:

Referral Agency: Agency Phone:

Current Diagnosis

Current Risk or impairment to daily functioning (aggression, self-harm, environmental/family risks, medical concerns – include settings in which behaviors occur, as well as frequency and intensity).

Is family aware referral is being made? ☐ yes ☐ no

What was there response?

Return to Morgan Dodge via email mdodge@orchadplace.org