Allegheny County Department of Human Services
Service Coordination Referral Form **CHILD/ADOLESCENT SERVICES**

REFERRAL DATE:	SERVICE PARTICIPANT NAME:

FORM INSTRUCTIONS

1. Only ONE service provider can be requested at a time.
2. Please be specific when describing the need for Service Coordination.
3. All sections of this document must be completed thoroughly and typed in order to make a determination of services.
4. Items should not be left blank-please indicate N/A where appropriate.
5. Incomplete referrals will not be accepted.
6. A current psychiatric or psychological evaluation (completed by MD) within past 12 months, and a list of the most recent medications must be attached with the referral.
7. The signature of the person being referred, or Guardian is required indicating that they understand that a referral is being made. ** If the person is unable to sign, the referral source must state if it is due to current symptoms, physical limitations, or other.
8. Email is preferred, unless delineated by specific provider.
9. Only fax if necessary or delineated by specific provider preference.

REFERRAL SOURCE RESPONSIBILITY

1. If Service Coordination Unit is unable to contact the referred individual, the referral source will be responsible for assisting the Service Coordination Unit in contacting the referred Individual or Guardian.
2. If an individual is being referred by a hospital, the referral should be submitted as soon as it is recognized that they are in need of Service Coordination. This will permit the SC to meet with the service participant before they are discharged from the inpatient unit.

NAME OF PROVIDER REFERRAL IS BEING MADE (**ONLY ONE** may be selected):

☐ ACI ☐ Chartiers ☐ HSAO ☐ MYCS ☐ Pgh Mercy ☐ Pressley Ridge ☐ Staunton ☐ TCV ☐ WFS ☐ WPH

ALLEGHENY COUNTY CHILD/ADOLESCENT SERVICE COORDINATION PROVIDERS

Allegheny Children's Initiative (ACI)
412-431-8006 (Ph)
412-431-8124 (Fax)
ACI-Intake@pfq.org

Chartiers Center
412-221-3302 (Ph)
412-257-2008 (**Fax- preferred**)
mturk@chartierscenter.org

Human Services Administration Organization (HSAO)
412-884-4500 (Ph)
412-885-3900 (Fax)
ahood@hsao.org

Mon- Yough Community Services (MYCS)
412-675-8480 (Ph)
412-664-0109 (Fax)
MYCSFAXADULTSC@UPMC.edu

Pittsburgh Mercy
412-323-8026 (Ph)
412-320-2376 (Fax)
SCREFERRALS@PittsburghMercy.org

Pressley Ridge
412-442-2080 (Ph)
412-321-0508 (Fax)
bbelohlavek@pressleyridge.org
hschoss@pressleyridge.org

Staunton Clinic
412-749-7330 (Ph)
412-749-7765 **(Fax- preferred**)
rkyle@hvhs.org

Turtle Creek Valley (TCV)
412-351-0222 (Ph)
412-351-0695 (Fax)
twynn@tcv.net

Wesley Family Services (WFS)
724-230-2777 (Ph)
724-230-2778 (Fax)
Christina.Shaner@wfspa.org

Western Psychiatric Hospital (WPH)
412-204-9001 (Ph)
412-204-9134 (Fax)
BSCreferrals@upmc.edu

Section A. ELIGIBILITY CRITERIA

I. Persons eligible for Child/Adolescent Service Coordination are up to the age of 18 years (or to 21 if the Child/Adolescent has an Individualized Education Plan (IEP) or is transitioning to the adult system) who has a Diagnosis within the DSM IV R (or succeeding revisions thereafter) completed by a Doctor, excluding those with a principal diagnosis of Intellectual Disability (formerly mental retardation), psychoactive substance use, organic brain syndrome or V-Code.

II. Treatment History: Must have one (1) of the following:

☐	At risk for out-of-home placement without services.
☐	Returning from community inpatient or other out of home placement.
☐	Age 6 years or younger and require or enrolled in Early Intervention Services.
☐	Receiving with their family, services from 2 or more publicly funded programs.
☐	Transfer from another Service Coordination Provider Current Service Provider:
☐	Recommended as needing MH Services by local county interagency team.
☐	Currently receiving or in need of MH services or in need of services from two or more human services agencies or public systems such as Drug and Alcohol, CYF, Juvenile Probation, etc. Anticipated closure date:

III. Reason for referral: *Indicate **SPECIFIC REASON** how service Participant could benefit from Service Coordination, keeping in mind a need for transportation is NOT a reason for referral*

Section B. Referral Source Information

Referral Source Name:		Title:	
Agency Name:			
Phone #:		Cell #:	Fax #:
Email:			
Supervisor name:		Phone:	Email:

Section C. Service Participant Demographics

Name:	Last:		First:	
Alias Name:	Last:		First:	
Date of Birth:		Age:	SS #:	Gender:Choose One
Ethnicity:		Primary Language:		
Grade in School:		Name of School:		
Special Education:	☐ YES ☐ NO	Level:		
Permanent Address:	☐ *check here if Homeless*	Address:		Zip code
If checked Homeless above:	Identified contact Name:	Phone Number: Address:		
Current Address: (*if someplace other than permanent address)*	Facility Name:	Address:		Phone:
Contact Numbers	Home:	Cell:		Best time to call:
Email Address:				
Accommodations:	☐ TTY ☐ Interpreter ☐ Sign language ☐ Ambulatory limitations ☐ Other			

Parent:	Last Name:	First Name:
Parent Phone:	Home:	Cell:
Parent Email:		
Guardian Name:		Provider Affiliation: (If applicable)
Guardian Type:	☐ Medical/Educational Guardian ☐ Guardian ad litem ☐ Permanent legal custodian	
Guardian Phone:	Home:	Cell:
Guardian Email:		

Section D. Financial Information/Source of Income

Monthly Amount:		
Source of Income:	☐ SSI ☐ SSD ☐ Child Support (if applicable) ☐ Other:	
If source of income is pending, please describe and give date of application: SOAR Application: ☐ YES ☐ NO Date of application: Additional Information:		
Representative Payee Name: (if applicable)		Phone:
Power of Attorney: (if applicable)		Phone:

Section E. Health Insurance Information

Medical Assistance: ☐ Yes ☐ No	Medicare: ☐ Yes ☐ No	Other:
Medical Assistance or ID #:		

Section G. Health and Wellness

Known Allergies:
For 18 and Older: Does participant have a Mental Health Advanced Directive (MHAD) completed within 1 year: ☐ Yes ☐ No
For 18 and Older: Does participant have a Wellness Recovery Action Plan (WRAP) completed with 1 year: ☐ Yes ☐ No ***** If participant has a MHAD or WRAP Plan, please attach*****

Section H. Other Agency/Program Involvement LIST ALL ACTIVE SERVICES:

Program Support: ***(choose from drop-down menu)***	Agency:	Name of primary provider contact:	Phone:	Email:
Choose an item.				
Choose an item.				
Choose an item.				
Choose an item.				
Choose an item.				

☐ACSP ☐CIT	If Applicable to CSP/ACSP please attach plan
Has the individual previously received SC Services? ☐ Yes ☐ No If yes, previous provider:	
Has a referral been made to any housing programs ☐Yes ☐No If yes, date referral was made: Explanation/Type of Housing:	

Section I. Mental Health Information ***(DSM Diagnosis- Please attach a recent psychiatric evaluation or Doctor's signature to verify diagnosis completed within past 12 months).***

Please include a primary behavioral health diagnosis. Other diagnoses may be included

Behavioral Health:		Code:
Behavioral Health:		Code:
Medical Conditions:		
Medical Conditions:		
Last Psychiatric Eval:		Completed by:

Section J. Current Outpatient Provider/Services/Supports			
CURRENT PROVIDER	**PROVIDER AGENCY**	**CONTACT NAME**	**CONTACT PHONE NUMBER**
Outpatient Psychiatrist:			
Outpatient Therapist:			
Primary Care Physician:			
Medical Specialist:			
IBHS (BHRS):			
Family Based/Family Focused:			
Residential Treatment Facility:			

Section K. Risk Factors *(Additional sheets can be attached if needed)*	Yes	No	Time Frame
Suicidal ideation/attempt? Explain:	☐	☐	
Self- injurious behaviors? Explain:	☐	☐	
Physical Harm to Others? Explain:	☐	☐	
Victimization of Others? Explain:	☐	☐	
Destruction of Property? Explain:	☐	☐	
Fire Setting? Explain:	☐	☐	
Sexually Inappropriate or Offensive Behaviors? Explain:	☐	☐	
Megan's Law Registry? Explain:	☐	☐	
Probation: Explain**:**	☐	☐	
Protection from Abuse (PFA)? Domestic Violence? Explain:	☐	☐	
Risk of Eviction or homelessness? Explain:	☐	☐	
Access to weapons in the home or elsewhere? Explain:	☐	☐	
Gang Involvement? Explain:	☐	☐	
Major Medical concerns? Explain:	☐	☐	

Pets in the home? Explain:	☐	☐	
School Problems?	☐	☐	
Family Concerns?	☐	☐	
Other?	☐	☐	

Section L. Legal History *(attach additional sheets if needed)*

CRIMINAL CHARGES CURRENT/ PAST 5 YEARS ***(choose from drop-down menu)***	**ARREST DATE** **(IF APPLICABLE)**	**OUTCOME OF ARREST (IF APPLICABLE)**	**RELEASE DATE** **(IF APPLICABLE)**	**CONVICTED**	**CONVICTION/ DISPOSITION (IF APPLICABLE)** ***(choose from drop-down menu)***
Choose an item.		Choose an item.		☐ **YES** ☐ **NO**	Choose an item.
Choose an item.		Choose an item.		☐ **YES** ☐ **NO**	Choose an item.
Choose an item.		Choose an item.		☐ **YES** ☐ **NO**	Choose an item.
Choose an item.		Choose an item.		☐ **YES** ☐ **NO**	Choose an item.
Choose an item.		Choose an item.		☐ **YES** ☐ **NO**	Choose an item.
Choose an item.		Choose an item.		☐ **YES** ☐ **NO**	Choose an item.

If OTHER Charge Identified Explain:

Section M. AUTHORIZATION FORM

I agree to this referral and authorization. In an event I cannot be reached, or additional information is needed, I authorize other service providers or organizations listed on this referral be contacted on my behalf for the purpose of coordinating this referral.

Print Name _____ Date _____

Service Participant Signature (14 or older): _____

Print Name _____ Date _____

Guardian Signature _____

Print Name _____ Date _____

Referral Source Signature _____

Is Service Participant agreeable to services? ☐ Yes ☐ No
If No, explain: