CONNECTICUT CARE COORDINATION REFERRAL FORM

Residents of Southeastern CT:
Fax to the attention of Paula Patton
UCFS Care Coordination Supervisor
Fax: 860-859-4420
Phone: 860-822-4301

Youth Name:
Date of Birth: Age:
Gender: ☐ Male ☐ Female
Residing Address: ***Include apartment # or floor***
.
Parent/Guardian Name(s): Parent Date of Birth:_____ ***optional***
Relationship to Youth: # of other children in home:
# of other adults in home:

Phone: ***List all possible phone #s***
(home) (work) (cell)
Best day & 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 do the youth and family consider to be their main challenges: ***Explain the emotional/behavioral challenges that the child/youth presents at home, in school & in the community***

Provider Concerns: ***Behaviors, Recent Trauma, Relevant Family Medical Info***

What are the safety concerns for the youth and family:

Current Supports including secondary parent if applicable: ***school, friends, neighbors, family, providers, community***

NAME:	ROLE/Relationship to:	PHONE:

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** F-codes:

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

"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 regulations:

☐ 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.