COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT
Referral Form

Child's Legal Name: _____ Gender: _____

Social Security Number: _____ Date of Birth: _____

Medicaid Number: _____ Race: _____

Legal Status: ☐ In DCF custody ☐ Shelter Status ☐ Foster Care ☐ Adoptions ☐ Other (Specify): _____
Family Safety Custody Date (If Applicable): _____
Child's current living arrangements:
Caretaker/Agency Name: _____
Street Address: _____ City: _____
Phone: _____

Referral Source/Contact Name: Aimee Deen
Phone: 208-2304 Fax: _____

Shelter Status applicants skip this section:

This child meets the following criteria required by the Community Mental Health Services Coverage and Limitations Handbook (Check all that apply):

☐ Be experiencing serious emotional disturbance;
☐ Be a victim of abuse or neglect; and
☐ Have been determined by the Department of Children and Families; District Family Safety Program Office to require out-of-home care,

OR

☐ Have committed act of juvenile delinquency,
☐ Be suffering from serious emotional disturbance; and
☐ Have been adjudicated delinquent and committed to the Department of Juvenile Justice; and the Court must have ordered low-risk resident community Commitment setting for the child,

OR

☐ Be a victim of abuse or neglect; and
☐ Have been determined by the Department of Children and Families, District Family Safety Program Office to require out-of-home care.

Forward to CARE Team.

FOR OFFICE USE ONLY:

Date Referral was received:_____ Date Referred for Assessment: _____
Date Assessment returned completed: _____ Date Forwarded to Referral Source: _____