CHJC Human Services & Community-Based Programs

To Submit Referral: **Email:** HBCI@chjc.org **Fax:** (315) 779-1184	**For Referral Questions:** (315) 418-5572

Home Based Crisis Intervention Referral

DEMOGRAPHICS

Name (Last, First, MI):		**Date of Birth:**
Chosen Name:	**Legal Gender:**	**Pronouns in Use:**
Address:	**County of Residence:**	**Phone:**

CAREGIVER INFORMATION

Caregiver #1:		**Caregiver #2:**	
Relationship to Child:	**Legal Guardian:** ☐ **Yes** ☐ **No**	**Relationship to Child:**	**Legal Guardian:** ☐ **Yes** ☐ **No**
Address (if different from youth):		**Address (if different from youth):**	
Phone:	**Email:**	**Phone:**	**Email:**
Leave VM: ☐ **Yes** ☐ **No**	**Text:** ☐ **Yes** ☐ **No**	**Leave VM:** ☐ **Yes** ☐ **No**	**Text:** ☐ **Yes** ☐ **No**

CONSENT TO REFER *Consent to make this referral must be obtained from the parent/guardian/legally authorized representative up to the age of 18. Children/Youth ages 18-20, or those who are married, a parent, or pregnant, may consent on their own behalf. *If signed by legal guardian, please provide guardianship documentation.*

Name of Consenter:	**Signature:**	**Date:**

Reason for Referral

Appropriateness Criteria (Check all that apply): ☐ Age 5-20 ☐ Experiencing mental health crisis ☐ Non-suicidal self-injurious behaviors ☐ Suicidal ideations/threats/attempts ☐ Homicidal ideations/threats/attempts ☐ Number of Emergency Department visits in past 12-months ____ ☐ Number of Psychiatric Inpatient Admissions in past 12-months ____ ☐ History of placement in Community Residence (CR), Residential Treatment Facility (RTF), or Residential Treatment Center (RTC)	**Summary of Need** (may use additional page):

INSURANCE

Name of Insurance Provider:	**Medicaid CIN# (if applicable):**

CURRENT PROVIDERS

Therapist/Agency:	**Psychiatrist/Agency:**
Other Providers:	**Diagnosis:**

REFERRAL SOURCE

Name/Title:	**Organization:**
Phone:	**Email:**

(Admin Use Only)
Date Referral Received:

Name (Last, First, MI):	**Date of Birth:**

Summary of Need (continued):

(Admin Use Only)
Date Referral Received: