Crisis Diversion
Ancillary Services Referral Form

☐ FOCIS

Today's Date: __/__/____		
Client Name: _____		
Client Address: _____ **City:** _____ **State:** __ **Zip Code:** _____		
Date of Birth: __/__/____ **Age:** __	**Sex:** ☐ Male ☐ Female	**Ethnicity:** _____
Parent(s) / Legal Guardian(s) Name: _____		
Siblings or others in the household: _____		
Address: _____ **City:** _____ **State:** __ **Zip Code:**_____		
Home Phone: ( ) -	**Work Phone:** ( ) -	**Cell Phone:** ( ) -
Current Placement: Select Placement		
Reasons for referral to IFD/Homebuilders, FOCIS – Include most current risk factors (eg. current presenting problem, imminent issues): _____		
Potential in-home safety risks: _____		

RSN Provider: Select Provider	**Provider Phone No.:** ( ) -
RSN MHCP Name: _____	**MHCP Phone No.:** ( ) -
RSN DCFS Social Worker: _____	**Social Worker Phone No.:** ( ) -
JPO: _____	**JPO Phone No.:** ( ) -

Current School: _____	**School District:** _____
Grade: Select Grade	**Enrolled In:** Please Select
School District Contact: _____	**Phone No.:** ( ) -

Most Current Psychiatric Diagnoses: (DSM V) within the last six (6) months	
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
Current CGAS:	_____

Current Psychotropic Medications		
Medication	**Dosage**	**Directions**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Psychiatrist / Medication Manager: _____	**Phone No.:** ( ) -
Current Presenting Problem(s): _____	
Primary Medical Doctor: _____	**Phone No.:** ( ) -
Pervasive Medical Problem(s): _____	
Current Legal Involvement: _____	

Prior Psychiatric Hospitalizations		
Date	**Location**	**Duration of Stay**
__/__/____	_____	_____
__/__/____	_____	_____
__/__/____	_____	_____
__/__/____	_____	_____

Other Ancillary Programs Involved In	**Dates**
Please Select Program	_____
Please Select Program	_____
_____	_____
_____	_____

Treatment expectations – Be as specific as possible: _____

Please list strengths / coping skills of both child and family	
Child	_____
Family	_____

Check all that apply:

☐ **Physically Violent**	☐ **Sexual Aggression**	☐ **Sexual Abuse**
☐ **Gang Involvement**	☐ **Substance Abuse**	☐ **Runaway**
☐ **Suicidal**	☐ **Domestic Violence**	☐ **Fire Setting**

☐ **Other :** _____

☐ **Current LRA** **Expiration date: / /**

Family Agreement

We understand that our family is being considered for referral to the _____program. This program is intended to divert from, or assist in stepping down from, psychiatric hospitalization. We understand that the _____ program is an **intensive, in-home**, **family counseling program**. Therapists typically meet with family members **3-5 times per week** (more if needed), for a total of **40 or more face-to-face contact hours over 4 weeks**. Therapists work with family members to develop a service plan that meets the needs of family members, and that decreases the likelihood of hospitalization. If approved for services, we agree to:

Be available for an intake session within 24 hours of approval;
Be available to meet with the assigned therapist (typically 3-5 times per week, as described above).
**For FOCIS only: Agree to having a therapeutic aid(TA) to assist therapist with the applications of skills, interventions up to 12 hours per week in home

Signature: _____ Date: _____
Parent

Signature: _____ Date: _____
Youth

Provider Agreement

As primary therapist requesting ancillary services I agree to actively participate in treatment and discharge planning. I will maintain regularly scheduled therapy sessions in conjunction with ancillary treatment goals, and to maintain regular contact with ancillary therapist.

Signature: _____ Date: _____

Provider: _____

Required Attachments
The following items **must** be attached to the completed application by the primary MHCP prior to being sent for review by the ancillary agency:
☐ Agency ROI to FOCIS
☐ Guardianship/Power of Attorney paperwork
☐ Current Agency Intake
☐ Most Recent Treatment Plan
☐ GAIN SS (if applicable)
☐ Most Recent Crisis Plan (if applicable)
☐ Most Recent Psychological Assessment (if applicable)
☐ Most Recent Psychiatric Evaluation (if applicable)