Intensive Customized Care Coordination
ICC Referral Form

Referral Date: Youth Name:

Date of Birth: Age:

Social Security Number: Gender Assigned at Birth:

Race: Primary Language:

Parent/Guardian Name: Relationship to Youth:

Phone Number: Email:

Address: Residing County:

School Grade Level:

Special School Services: ☐ IEP ☐ 504 Other:

Youth's Insurance: Insurance Policy Number:

Referring Organization: Referring Individual:

Contact Number: Contact Email:

Other Agencies Involved in Youth's Care:

Does youth have a history of substance abuse?

☐ Yes ☐ No ☐ Unknown

Mental Health Diagnosis:

Medical Diagnosis:

Response to Current Treatment:

Is youth able to meet basic needs, fulfill usual role to maintain health and wellness?

☐ Yes ☐ No ☐ Unknown

Does the youth currently take any prescribed medications?

☐ Yes ☐ No ☐ Unknown

If yes, please list medications, dosage, and frequency here:

Presenting Problems:

☐ Self-Harm ☐ Homicidal Ideation/Behavior

☐ Suicidal Ideation ☐ Active Substance Abuse

☐Sexual Offense
☐Threats of Violence
☐Suicide Attempt
☐Runaway
☐Imminent Risk of Out of Home
☐Placement
☐Fire Setting/Property Destruction

Other:

Provide Details of the Presenting Problems listed:

Has the parent/guardian been informed about the services provided by Aspire BHDD and provided consent for this referral to be placed?

☐Yes ☐No

Please send a copy of any supporting documentation you may have with this referral. This could include Diagnosis Verification, Behavioral Health Assessment, CSU/PRTF discharge papers, Psychological/Psychiatric Assessment, DR. Apt note, CANS, ANSA, and a copy of Insurance Cards. **Without supporting documentation, we will be unable to move forward in the referral process.**

*****Reminder*****

If the youth is 18 to 20 years old, they will need to accept Wraparound, unless under the custody of DFCS or DJJ.

Phone Number: 229-349-6868 Email: impact@albanycsb.org