

Montgomery County Federation of Families for Children's Mental Health

301-879-5200 (p) 301-879-0012 (f) www.mcfof.org

13321 New Hampshire Avenue, Terrace B Silver Spring, MD 20904

Referral Form for Peer Support Services

Please check the appropriate	box below. The person making the refer	ring is:
☐ Self-Referral - Family requ	esting assistance	
☐ Self-Referral – Youth/Your	ng Adult requesting assistance	
☐ Community Referral		
☐ Agency/Program Referral		
☐ Interagency Family Preser	vation Services (IFPS) Referral from YMC	A Youth & Family Services
DATE OF REFERRAL:		
	REFERRAL SOURCE'S INFORMA	ATION
NOTE: Parent/Pri	imary Caregiver or Youth/Young Adult co	an self-refer to the program.
Name of Person Making the	Referral	
_	n a specific agency/program, please prov	
Street Address		
City	State	Zip
Work Number	Cell Phone	Fax
Email		
	I ON PARENT/PRIMARY CAREGIVEI	
	egiver	
Ethnicity of Parent/Primary	Caregiver	
Relation of Youth to Parent/F	Primary Caregiver:	
Street Address of Parent/Prir	nary Caregiver	
City	State	Zip
Home Phone	Work	
Cell Phone	Fax	
Primary language of parent/p	orimary caregiver	
Other languages spoken in h	ome	
Email		

INFORMATION ON YOUTH/YOUNG ADULT NEEDING ASSISTANCE

Name of Youth/Young Adult	Needing Assi	stance			
Male Female Tra	ansgender	Other		Age	Birthdate
Ethnicity of Young/Young Ad	ult				
Street Address of Youth/You	ng Adult				
City			State		Zip
Telephone: Home Work				Cell Phone	
Fax		Email			
Where is the youth living?					
Biological Parent(s)	Adoptive	e Parent(s)	Relatives	Foste	er Care
Friends	Group Home Resi		Residentia	ential Treatment Center (RTC)	
Shelter/Homeless	Other _				
Siblings in the home					
AGENCY INVOLVEMENT OF Y					
□ EDUCATION Is youth/young adult attendi If attending school, is the young adult attending school, is the young adult attending school, is the young adult attending school, is the young school attending school and school adult attending school attending school attending school attending school attending school adult attending school, is the young school adult attending school, is the young school adult attending school, is the young school adult attending school adult attend	outh in	School Att Voo Departi Child W Develo	tending cational Progr ment of Juven	am	
Other					
MENTAL HEALTH DIAGNOSIS			<u> </u>	Vaa	NI
Does the youth/young adult		_		Yes	No
If yes, what us the mental he	aitii uiagiiOSI	ɔ:			
INSURANCE					
Does the youth/young adult	have insuran	ce? Y	'es	No	
If yes, what insurance does t	he youth/you	ing adult have	:?		

Is the youth/young adult employed?	Yes	No					
Is the youth/young adult underemployed?	Yes	No					
DISCONNECTED YOUTH							
Is the youth disconnected (not in school and not	working)?	Yes	No				
ASSIS What type of assistance does the parent/primar	ry caregiver need?						
What type of assistance does the youth/young ad	dult need?						
PLEASE RETURN COMPLETED REFERRAL FORM TO <u>BOTH</u> STAFF LISTED BELOW: Celia Serkin, Executive Director, <u>cserkin@mcfof.org</u> Mary Kackley-Harris, Family Support Partner, <u>mkackley@mcfof.org</u> Fax Number: 301-879-0012							
TO BE COMPLETED BY MONTGOMERY CO	OUNTY FEDERATION	OF FAMILIES	FOR CHILDREN'S				
Family Services Provider assigned to fam	nily, youth, and/or y	oung adult:					
Date:							

EMPLOYMENT

MONTGOMERY COUNTY FEDERATION OF FAMILIES FOR CHILDREN'S MENTAL HEALTH

Consent to Release/Receive Confidential Information

(Please Print)		
NAME OF CHILD/YOUTH:	DATE OF BIRTI	H / AGE:
NAME OF RESPONSIBLE FAMILY MEMBER	R/LEGAL GUARDIAN	
I give permission to the Montgomery County F written communication with the organizational purpose of coordinating and planning services	representatives and others listed below. T	
Codes for type of information: 1. All information/ Open communication 2. Discharge Summary 3. Health/Physical Examination 4. IEP (Individualized Education Plan) 5. IFSP (Individualized Family Service Plan)	6. Initial Assessment/Evaluation Reports7. Medical Reports/Hospitalization Dates8. Occupational Therapy Reports9. Physical Therapy Reports10. Progress Reports	11. Psychological Reports12. Social Histories/Reports13. Speech Therapy Reports14. Treatment Plans15. Other (Please specify)
I give my consent to share information:	Write Code	Contact Name
□ Name of school in cluster area □ Child Welfare Services □ Department of Juvenile Justice □ Multicultural Program □ Linkages to Learning □ Name of Mental Health Provider □ Emergency Services □ Montgomery County Police □ Department of Recreation (County) □ JSSA □ Local Access Mechanism at the Collaboration □ Other Other □ Other □ Other Other		(if applicable)
I understand that I can withdraw this consent a	at any time.	
Signature of Youth (if 18 or older)		Date
Signature of Parent or Guardian		Date
Signature of Family Services Provider from the Mon Families for Children's Mental Health	ntgomery County Federation of	Date
Signature of Family Services Provider's Supervisor Federation of Families Children's Mental Health	or from the Montgomery County	Date