Montgomery County Federation of Families for Children's Mental Health

13321 New Hampshire Ave., Suite 101
Silver Spring, MD 20904

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

Referral Form for Peer Support Services

Please check the appropriate box below. The person making the referring is:

- ❑ Self-Referral - Family requesting assistance
- ❑ Self-Referral – Youth/Young Adult requesting assistance
- ❑ Community Referral
- ❑ Agency/Program Referral
- ❑ Interagency Family Preservation Services (IFPS) Referral from YMCA Youth & Family Services

DATE OF REFERRAL: _____

REFERRAL SOURCE'S INFORMATION

(NOTE: Parent/Primary Caregiver or Youth/Young Adult can self-refer to the program.)

Name of Person Making the Referral _____

If the referral is coming from a specific agency/program, please indicate which one:

_____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ Cell Phone _____Email_____

Email_____

INFORMATION ON PARENT/PRIMARY CAREGIVER NEEDING ASSISTANCE

Name of Parent/Primary Caregiver_____

Ethnicity of Parent/Primary Caregiver_____

Name of Youth _____

Relation of Youth to Parent/Primary Caregiver: _____

Street Address of Parent/Primary Caregiver_____

City _____ State _____ Zip _____

Telephone: Home _____ Work _____ Cell Phone _____

Fax _____ Email _____

Primary language of parent/primary caregiver_____

Other languages spoken in home _____

INFORMATION ON YOUTH/YOUNG ADULT NEEDING ASSISTANCE

Name of Youth/Young Adult Needing Assistance_____

❑ Male ❑ Female ❑ Transgender Age _____ Birthdate _____

Ethnicity of Young/Young Adult _____

Street Address of Youth/Young Adult_____

City _____ State _____ Zip _____

Telephone: Home _____ Work _____ Cell Phone _____

Fax _____ Email _____

Where is the youth living?

❑ Biological Parent(s) ❑ Adoptive Parents ❑ Relatives ❑ Foster care

❑ Friends ❑ Group Home ❑ Residential Treatment Center (RTC)

❑ Shelter /Homeless ❑ Other _____

Siblings in the home _____

YOUTH'S AGENCY INVOLVEMENT

EDUCATION

❑ Attending school ❑ Not attending school

If attending school, is the youth in ❑ Regular Education ❑ Special Education ❑ 504 Plan

Grade _____ School Attending _____

College Attending _____ Vocational Program_____

OTHER AGENCIES INVOLVEMENT

❑ Behavioral Health
- Mental Health
- Substance Use
- Co-Occurring (Mental Health and Substance Use)

❑ Department of Juvenile Services

❑ Child Welfare

❑ Developmental Disabilities

❑ Other_____

(*Please specify*)

EMPLOYMENT

Is the youth employed? ❑ Yes ❑ No

Is the youth underemployed? ❑ Yes ❑ No

DISCONNECTED YOUTH

Is the youth disconnected (not in school and not working)? ❑ Yes ❑ No

What type of assistance does the parent/primary caregiver need?

_____

_____

_____

_____

What type of assistance does the youth/young adult need?

_____

_____

_____

_____

PLEASE RETURN COMPLETED REFERRAL FORM TO BOTH STAFF LISTED BELOW:
Celia Serkin, Executive Director, cserkin@mcfof.org
Mary Kackley-Harris, Family Support Partner, mkackley@mcfof.org
Fax Number: 301-879-0012

TO BE COMPLETED BY MONTGOMERY COUNTY FEDERATION OF FAMILIES FOR CHILDREN'S MENTAL HEALTH USE ONLY:

Peer Support Partner assigned to family, youth, and/or young adult:

_____

Date: _____

MONTGOMERY COUNTY FEDERATION OF FAMILIES FOR CHILDREN'S MENTAL HEALTH

Consent to Release/Receive Confidential Information

(Please Print)

NAME OF CHILD/YOUTH:_____ DATE OF BIRTH / AGE: _____

NAME OF RESPONSIBLE FAMILY MEMBER/LEGAL GUARDIAN _____

I give permission to the Montgomery County Federation of Families for Children's Mental Health to engage in oral and/or written communication with the organizational representatives and others listed below. This permission is given for the purpose of coordinating and planning services and providing family support.

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 Reports
7. Medical Reports/Hospitalization Dates
8. Occupational Therapy Reports
9. Physical Therapy Reports
10. Progress Reports
11. Psychological Reports
12. Social Histories/Reports
13. Speech Therapy Reports
14. Treatment Plans
15. Other (Please specify)

_____

I give my consent to share information:	**Write Code**	**Contact Name (if applicable)**
❑ 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 Council		
❑ Other		
❑ Other		
❑ Other		
❑ Other		

This authorization is valid (check one):

- ❑ Until: _____
- ❑ For one year from today's date:_____

- ❑ ***I understand that I can withdraw this consent at any time.***

_____ _____
Signature of Youth (if 18 or older) *Date*

_____ _____
Signature of Parent or Guardian *Date*

_____ _____
Signature of Program Staff from the Montgomery County Federation of Families for Children's Mental Health) *Date*

Reviewed by Family Services Supervisor

Signature of Family Services Supervisor _____ _____
Date