Intensive Customized Care Coordination (IC3/High Fidelity Wraparound) Referral

Please submit a completed IC3 referral and supporting documentation (*diagnosis verification, CSU/PRTF discharge paperwork, assessments, copy of insurance cards, etc.)* to one of the following Care Management Entities using the email address below:

☐ aspire — impact@albanycsb.org

☐ Community Service Board Middle Georgia — hope@csbmg.com

☐ View Point Health — FamilyWrap@vphealth.org

☑ WIN georgia — winga@lmcs.org

Referral Date: _____

Youth's Information

First Name: _____ Last Name: _____ DOB: _____ Age: _____

Birth Gender: _____ Gender Identity: _____ Youth SS# (If available): _____

Race: _____ Primary Language: _____ Secondary Language: _____

School Attending: _____ School Grade: _____

Special School Services: _____ ☐ IEP ☐ 504 Plan

Primary Insurance Carrier: _____ Primary Insurance Number:_____

Secondary Insurance Carrier: _____ Secondary Insurance Number: _____

Medicaid # (if applicable): _____

Parent/Guardian's Information

Name: _____ Relationship to youth: _____

Address: _____ City: _____ Zip:_____

County: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Email: _____

Additional Contact's Information

Name: _____ Relationship to Youth: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Email: _____

Youth in DFCS Custody: ☐ No ☐ Yes

If Yes - Name of DFCS CM _____ County _____

Contact Phone_____ Email Address_____

Referring Party's Information - Name: _____ Phone: _____

Email: _____

Referring Party's Agency or Relationship to Youth: *(Please select one)*

☐ Parent/Guardian	☐ DBHDD Core Provider	☐ System of Care (LIPT/CHINS/CSEC)
☐ Inpatient Hospital	☐ Private Provider or Pediatrician	☐ School System
☐ Residential Facility (PRTF)	☐ Juvenile Court	☐ Crisis Stabilization Unit (CSU)
☐ DJJ In Community	☐ DFCS Family Preservation	☐ Family Support Organization
☐ DJJ Secure Facility	☐ DFCS Custody (GA Families 360)	☐ Other: _____

Other Agencies Currently Involved:

☐ Enrolled in School (check if YES)	☐ DBHDD Core Provider	☐ Family Support Organization
☐ Inpatient Hospital	☐ Private Provider or Pediatrician	☐ Law Enforcement
☐ PRTF (Residential Facility)	☐ Juvenile Court	☐ Crisis Stabilization Unit
☐ Child Caring Inst. (Group Home)	☐ DFCS (non-custody only)	☐ Georgia Cares (CSEC)
☐ Dept. of Juvenile Justice	☐ DFCS Custody (GA Families 360)	☐ Other: _____

Has the youth been presented at one of the following: ☐ LIPT ☐ CHINS ☐ MATCH

Mental Health Diagnoses: _____

Substance Use Diagnosis: _____ Developmental / IDD Diagnosis: _____

Current Medication *(Include date prescribed, if known)*: _____

Do you have a GA CANS you are able to share with us? ☐ Yes ☐ No

What is the reason for the referral? *(i.e. challenges the youth is facing at home, in school, and in the community*):

Please include a brief history of the youth/family: *(Discuss information that would be important and beneficial to know)*

Presenting Problems/Risk: *(Please select all applicable emergent and crisis needs that have occurred within the last 6 months)*

☐ Self-harm ☐ Suicidal thoughts ☐ Suicide attempt ☐ Threats of Violence ☐ Homicidal thoughts/behaviors
☐ Runaway ☐ Sexual Aggression ☐ Delinquent Behavior ☐ Intentional Behaviors ☐ Runaway
☐ Property Destruction/Fire Setting ☐ Active Substance Use ☐ Imminent Risk of Out-of-Home Placement
☐ Other: _____

Emotional/Behavioral Needs: *(Please select areas in which the youth demonstrated need for monitoring, action, or intervention)*

☐ Psychosis ☐ Attention/Concentration ☐ Impulsivity ☐ Depression ☐ Anxiety
☐ Substance Abuse ☐ Attachment Difficulties ☐ Anger Control ☐ PTSD ☐ Phobia
☐ Conduct ☐ Obsessions/Compulsion ☐ Oppositional ☐ Adjustment to Trauma
☐ Other: _____

Past or current exposure to Potentially Traumatic / Adverse Childhood Experiences: *(Please select all that apply)*

☐ Sexual Abuse ☐ Witness to Family Violence ☐ Emotional Abuse ☐ Physical Abuse ☐ Neglect
☐ Community Violence ☐ Parental Criminal Behavior ☐ School Violence
☐ Disruptions in Caregiving/Attachment Losses ☐ Other: _____

Life Functioning Needs: *(Please select the areas in which the youth demonstrated need for monitoring, action, or intervention)*

☐ Family ☐ Living Situation ☐ Social Functioning ☐ Legal ☐ Sleep
☐ Recreational ☐ School Behavior ☐ School Attendance ☐ Decision Making ☐ School Achievement
☐ Recreational ☐ Developmental ☐ Recreational ☐ Job Functioning ☐ Legal
☐ Medical/Physical ☐ Sexual Development

Please select any of the following services the youth has received in the past 6 months:

☐ Inpatient Hospital *# of Inpatient Admissions:* ____ ☐ Residential Treatment Facility *# of PRTF Admissions:* _____	☐ DJJ ☐ DFCS / CCI / CPA ☐ Juvenile Court ☐ RYDC - *# of Stays:* _____	☐ Youth Development Center ☐ Crisis Stabilization Unit *# of CSU Admissions*: ___ ☐ Other: _____

Has the family been informed about IC3 services and consented to the referral? ☐ Yes ☐ No