In-Home Skills Referral Form

In-Home skills practitioners provide rehabilitative skills to children, adolescents and transitional age youth that are **Washington County Residents AND are at high risk of out of home placement** into Residential Treatment, Group Home, or Foster Home care. Services are offered to individuals, families and in groups and can be delivered in-home, in-school and in community.

Date of Referral________________________

Referring Person________________________Phone__________Agency/Facility_______________________

Name of Child ___________________________DOB _______Age ___Sex ___Race____________________

Family Address ____
Family Phone____________________________

Present Location of Child____

Identify family members:

Name | Relationship to Child | Age | Location

____

____

____

____

Child's Diagnosis____

Completed by_____________________________________Date_________________________

Reason for referral (presenting problem that would necessitate rehabilitative skills)

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____
____
____
____
____

Skills being requested:

Individual Skills ______ Family Skills ______Therapy ______Group ______Solid Ground Class ______

Social skills: ____
Mood regulation skills:____
Independent living skills:____
Self-Care skills:____
Other:____

Current services being delivered:

☐ Psychiatrist Name: ______________________________Phone: ____________
☐ Case Manager Name: ______________________________Phone: ____________
☐ County Social Worker Name: ______________________________Phone: ____________
☐ Individual Therapist Name: ______________________________Phone: ____________
☐ Family Therapist Name: ______________________________Phone: ____________
☐ Day Treatment Name: ______________________________Phone: ____________
☐ Foster Care Name: ______________________________Phone: ____________
☐ Court Services Name: ______________________________Phone: ____________
☐ Chemical Health Name: ______________________________Phone: ____________
☐ School Case Manager Name: ______________________________Phone: ____________
☐ Other (specify) Name: ______________________________Phone: ____________

Do other providers support this referral? ______________
How would skills work fit in with other services?____
____
____

Funding: (***Must have MA, PMAP or is SELF eligible to bill skills**.* If therapy is warranted we can provide that regardless of insurance)):

Is youth eligible for SELF? ☐ Yes ☐ No Has SELF Plan been written? ☐ Yes ☐ No

Does youth have a CADI Waiver that covers Independent Living Skills Services? ☐ Yes ☐ No

Insurance Company____

ID#________________________________Group_______________________

Policy Holder____DOB__________________

What other services have been tried?

____

____

____

____

What were the results of other services?

____

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____

____

Outstanding medical issues for child and/or family members:

____

____

____

____

Mental health issues for family members:

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____

____

Is the client taking medication? ☐ Yes- ☐ No

If yes, what type?

Prescribed by whom?

Are there chemical health concerns for the child? ☐ Yes ☐ No ☐ Unsure

Chemical health concerns for family members? ☐ Yes ☐ No ☐ Unsure

What school does client attend? ____ Grade: _____

Can client be seen at school? ____

School Functioning (circle appropriate number):

	Serious Problem									**Not a Problem**
Academic:	1	2	3	4	**5**	6	7	8	9	10
Behavior:	1	2	3	4	**5**	6	7	8	9	10

Level of Special Ed. Services: ___IEP____

List Behaviors at School:

What days and time is client/family available for appointments:____

____

Is there any other information you would like us to know?________________________________

____

____

Please mail or fax completed referral form to:

Dean Gorall, Ph.D., LMFT
Program Supervisor
In-Home Services/Family Treatment Program
Canvas Health
7066 Stillwater Blvd. North
Oakdale, MN 55128
Phone: 651-251-5045
Fax: 651-251-5204