Harford County Public Schools

School-Based Mental Health Referral 2020-2021

Student Name: ______________________________________Date of Birth: ________________

School: ____ Grade: _____________________

Referral Date: ____

Parent/Guardian Name: ____

Parent/Guardian Address: ____

Contact Number: ____

Medical Assistance: ☐ Yes ☐ No Private Insurance:☐ Yes ☐ No Type:___________

Medical Assistance Number or Social Security Number: _________________________________

Specific Description of Problem/Concern:

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Please Describe the barrier to community-based outpatient treatment and the need for School Based Services:

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Has the student's parent/guardian been notified of this referral? ☐ Yes ☐ No

Parent's Signature: ____
(*Verbal consent required*)
Referred to:

☐ School Based Mental Health Provider

☐ Empowering Minds Resource Center (Care Coordination Youth Targeted Case Management)