# Office on Mental Health

*Core Service Agency of Harford County, Inc.*
Phone: 410-803-8726 Fax: 410-803-8732

## RESPITE REFERRAL

**Program available only for youth with Medical Assistance**
**Form must be completed by a mental health professional**
**Child must be actively involved in outpatient mental health therapy**

Fax completed form to Angela Gray at number above or e-mail agray@harfordmentalhealth.org

**AGENCY INFORMATION:**

Referral Date: _____

Name/Position of person completing this form: _____

Referring Agency: _____ Phone #: _____

Email Address: _____

Relationship to Child/Adolescent: _____

Reason for Referral:

_____

Type of Respite Requested:

☐ In-home/community (Up to 8 hours per month for up to 12 months)

☐ Out-of-home* (Up to 2 weekends per month for up to 12 months. Child spends 1-2 weekends per month in the home of a therapeutic foster family transportation not provided.)

*How often?* _____

**CHILD/ADOLESCENT INFORMATION:**

Name: _____ Date of Birth: _____

Sex: ☐ M ☐ F Race: ☐ African American ☐ Caucasian ☐ Other

SS#: _____ MA#: _____

School: _____ Grade: _____

Has the child received respite services in the past? Please specify type of respite, program name, and dates of service.

_____

Child Currently resides with: ☐ Parents ☐ Mother ☐ Father ☐ Other: _____

Address: _____

Phone: _____

List household members/relationship/age: _____

_____ _____

_____ _____

Legal Custody/Guardianship: _____

Address: _____Phone: _____

***Name, Address, Phone of Current Mental Health Provider (s):*** _____

_____

***Frequency of Outpatient Mental Health Therapy (i.e. weekly, biweekly)*** _____

***Describe emotional and/or behavioral problems which stress the ability of the caregiver to provide for the youth in the home***:_____

***Please explain how activities of daily life are compromised for the caregiver:*** _____

***Please explain the risk to the caregiver***:_____

**Most Recent Diagnosis/ DSM 5 Diagnosis (Write out name of diagnoses)**

***DSM V Diagnosis:***

_____ - _____

_____ - _____

_____ - _____

_____ - _____

Medications: _____None

_____

***Individual Treatment Plan (ITP) goals related to RESPITE care service (write out a specific goal):***

**1.** _____

**2.** _____

**3.** _____

***Previous Placements:*** ____*Information Not Available*

| Type | Date | Agency |
|---|---|---|
| ☐ Therapeutic Foster Care | _____ | _____ |
| ☐ Therapeutic Group Home | _____ | _____ |
| ☐ Diagnostic Center | _____ | _____ |
| ☐ Shelter Care | _____ | _____ |
| ☐ Psychiatric Hospital | _____ | _____ |
| ☐ Residential Treatment Center | _____ | _____ |
| ☐ Detention Center | _____ | _____ |

***Other Agency Involvement / Relationship:***

☐ DSS
☐ DJJ
☐ LEA
☐ DDA
☐ MHA
☐ OTHER_____

**CURRENT SERVICES**

*Please specify program name, contact name and phone number, if available*

- ☐ PRP:_____ Phone_____
- ☐ TBS:_____ Phone_____
- ☐ Respite:_____ Phone_____
- ☐ Psychiatrist: _____ Phone_____
- ☐ Pediatrician:_____ Phone_____
- ☐ Other:_____ Phone_____

***Problematic Behaviors/Concerns:*** *(H/O = History of; A=Active)*

| *H/O* | *A* | *H/O* | *A* | *H/O* | *A* |
|---|---|---|---|---|---|
| ☐ Abandonment issues | ☐ | ☐ Oppositional/Defiant | ☐ | ☐ Property destruction* | ☐ |
| ☐ Anxiety | ☐ | ☐ Phobia (s) | ☐ | ☐ Runaway | ☐ |
| ☐ Depression | ☐ | ☐ Psychosis | ☐ | ☐ School Problems | ☐ |
| ☐ Eating Disorder | ☐ | ☐ Self-Mutilation * | ☐ | ☐ Sexually Aggressive * | ☐ |
| ☐ Enuresis | ☐ | ☐ Suicidal* | ☐ | ☐ Sexually Provocative | ☐ |
| ☐ Hyperactive | ☐ | ☐ Alcohol Abuse | ☐ | ☐ Theft | ☐ |
| ☐ Impulsive | ☐ | ☐ Drug Abuse | ☐ | ☐ Verbally Aggressive | ☐ |
| ☐ Low self-esteem | ☐ | ☐ Tantrums | ☐ | ☐ Physically Aggressive* | ☐ |
| ☐ Lying | ☐ | ☐ Cruelty to Animals* | ☐ | ☐ Peer difficulties | ☐ |
| ☐ Mood fluctuations | ☐ | ☐ Fire setting* | ☐ | ☐ Hallucinations | ☐ |
| ☐ Parental addictions | ☐ | ☐ Domestic Violence | ☐ | ☐ Seizures | ☐ |
| ☐ Physical Abuse | ☐ | ☐ Sexual Abuse | ☐ | ☐ Neglect | ☐ |

☐ Other: _____

*Please provide where the behavior has been observed, intensity, frequency, and date of last occurrence for any items marked with an *:* _____

_____

_____

*Allergies, reactions, and treatment (medicine, food, insects, and plants):* _____

_____

*Physical/emotional health problems that the respite provider should be advised of*_____

_____

*Other pertinent information:* _____

_____

**Signature *(person completing this form)***_____ ***Date:*** _____

**************************************Parental Consent Must be Obtained*************************************

**CSA Only----------**

☐ ***Approved*** ☐ ***Denied***: _____

_____ _____

***Core Service Agency Child and Adolescent Program Monitor*** ***Date***

☐ Villa Maria (**In-Home Provider**)

2601 N. Howard Street
Suite 200
Baltimore, MD 21218
410-727-5520

☐ Children's Choice (**Out-of-Home Provider**)

6067 Harford Rd
Baltimore, Md 21214
Office: 410-319-9681

# CONSENT TO SHARE INFORMATION

_____
**Parent/ Guardian** (Print)

_____ _____
**Child's Name** (Print) **Child's Date of Birth**

I authorize _____ **(Outpatient Mental Health Provider)** to release or obtain information. Information that is requested will be used to develop an appropriate treatment plan for the individual enrolled in respite services. I understand that the permission expires after twelve (12) months from the date of signature and applies only to the release of information to/from the agency named checked above unless otherwise specified.

I understand that this information is necessary to provide additional treatment background and to better coordinate my child's care.

_____ _____
**Parent/ Guardian Signature** **Date**

_____ _____
**Witness** **Date**