Integrated Community Alternatives Network

# Children's Crisis Residence Referral Application

Please complete this referral application and submit the referral to childrenscrisisresidence@ican.family. Referrals can be made by Service Providers and/or Parent/Legal Guardian. Please note that this email is under 24/7 monitoring, and our Children's Crisis Residence Staff will respond within a timely manner. If a case consultation is needed immediately, please contact our Children's Crisis Residence main at 315-801-7329 and follow the prompts for referral services.

Admission Criteria:

- The child/youth must be between the ages of 10 and 17.
- The child/youth is experiencing acute psychological/emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved (e.g. collateral, provider, community member) to effectively resolve it; AND
- The child/youth demonstrates at least one of the following:
  - Impairment in mood/thought/behavior disruptive to home, school, or the community.
  - Behavior escalating to the extent that higher intensity services will likely be required.
  - The intervention is necessary to further evaluate, resolve, and/or stabilize the child/youth.
  - The child/youth is not at imminent risk of harm to self or others.

***If this is an immediate emergency and you fear your youth maybe at risk, please contact 911.***

For general information please contact:

Carrie Conte, Director of Crisis Services
Office Line: (315) 731-2689
Fax: (315) 731- 5620
Email: cconte@ican.family

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## YOUTH'S INFORMATION:

| Name: | Date of Birth: | Ethnicity: | Primary Language: | Gender: |
|---|---|---|---|---|
| Address: | | | | |
| SS#: | Medicaid#: | Insurance Name: | | |
| Private Insurance Name: | | Private Insurance #: | | |
| Parent/ Legal Guardian Name: | | Parent/Legal Guardian Address (if different): | | |
| Home phone: | Cell Phone: | Work Phone: | | |

## EMERGENCY CONTACTS (at least 3 are required):

| Name | Relationship | Address | Phone |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Reason for requesting Crisis Residence at this time:

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|---|
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## SIGNIFICANT BEHAVIORS CHECKLIST:

Please check off any behaviors that your child has exhibited in the past 3-6 months:

| LETHALITY | MENTAL HEALTH | SEXUALIZED BEHAVIORS | SAFETY & RISKS NEEDS |
|---|---|---|---|
| ☐Fire setting<br>☐Bed wetting/soiling (specify)<br>☐Stealing<br>☐Hurts animals<br>☐Physically Aggressive<br>☐Running away<br>☐Impulsive<br>☐Oppositional/Defiant<br>☐Lying/Story telling<br>☐Peer Issues<br>☐Substance Abuse<br>☐Other: | ☐ Inability to Regulate Emotions (uncontrollable crying, anger, or shutting down).<br>☐ Health related disease or diagnosis that may impact their Mental Health.<br>☐ Depressive symptoms<br>☐ Self-injurious Behaviors<br>☐ Eating disorders<br>☐ Sleep disorders<br>☐ Hallucinations/delusions<br>☐ Suicidal<br>☐ Other: | ☐Sexually reactive<br>☐Sexually aggressive<br>☐Inappropriate contact with another individual(s).<br>☐Other: | ☐Safety plan required<br>☐Involvement with criminal activity<br>☐Has been incarcerated or placed in a residential setting.<br>☐Drug/Alcohol abuse<br>☐Other: |

Any Behaviors checked off above, please explain why?

## YOUTH'S MENTAL HEALTH OR SERVICE PROVIDER INFORMATION (If Any):

| Psychiatrist: | Agency/Service Provider: | Address: | Phone: | Fax: |
|---|---|---|---|---|
| Diagnosis: | | Medication: | | |

Please list any previous service providers in this section:

| Agency: | Address: | Contact Information: |
|---|---|---|
| Agency: | Address: | Contact Information: |
| Agency: | Address: | Contact Information: |

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## YOUTH'S MEDICAL INFORMATION:

| Primary Care Physician: | Address: | Phone: | Fax: |
|---|---|---|---|
| | | | |

Please select any that apply to the youth's medical information:

☐Exposure to contagious disease (MRSA, etc.): Yes ☐ or No ☐, If yes explain:

☐Medical problems: Yes ☐ or No ☐, If yes explain:

☐Dietary restrictions

☐Physical handicap

☐Infectious disease

☐Failure to thrive

☐Any medical restrictions

☐Does the youth have any allergies?

Describe any on-going medical needs/concerns (asthma/seizures/heart conditions/diseases etc.):

| |
|---|
| |

## EDUCATIONAL INFORMATION:

| School: | Address: | Phone: |
|---|---|---|
| Guidance Counselor: | School Social Worker (If one is assigned): | Teacher: |
| Does the Youth have an IEP?<br>☐Yes or ☐No<br>If Yes, What Classification: | Does the Youth have a 504 Plan?<br>☐ Yes or ☐ No<br>If Yes, What Circumstances: | Any Educational Comments or Concerns: |

## REFERRING INFORMATION:

Service Provider:

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| Name of the Individual making the Referral: | Agency/Service Provider: | Role/Title: |
|---|---|---|
| Address: | | |
| Phone: / Fax: | Email: | |
| Signature: | Date: | |

Parent/Legal Guardian (**Note:** Parent/Legal guardian can make a referral without a service provider):

| Parent/Legal Guardian: | Relationship to the Youth: |
|---|---|
| Phone: | Fax (If any): |
| Address: | Email (If any): |
| Parent/Legal Guardian Signature: | Date: |