



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 line at 315-801-7329 and follow the prompts for referral services.

Admission Criteria:

- Children ages 5-19 can be referred to the crisis residence. If a child is not appropriate for admission, our team will assist the family in connecting with resources in the community, including mental health services available through ICAN.
- 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 may be at risk, please contact 911.

For general information please contact:

Stasia Darling

Children's Crisis Residence Program Manager

Office Line: (315) 922-8628

Email: sdarling@ican.family

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	Gender	
Address		
Social Security #	Medicaid #	Insurance Name
Private Insurance Name	Private Insurance #	

EMERGENCY CONTACTS (AT LEAST 3 REQUIRED)

Name	Relationship	Address	Phone #
Name	Relationship	Address	Phone #
Name	Relationship	Address	Phone #
Name	Relationship	Address	Phone #

REFERRING INFORMATION

Name of the Individual Making the Referral	Agency/Service Provider	Role/Title
Address		
Phone	Fax	Email
Signature	Date	

PRESENTING PROBLEMS

What factors contribute to the youth being at risk of an ER visit or hospitalization due to mental health crisis:

SIGNIFICANT BEHAVIORS CHECKLIST

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

Lethality

- | | | |
|--|--|--|
| ☐ Fire setting | ☐ Physically Aggressive | ☐ Lying/Story telling |
| ☐ Bed wetting/soiling (specify) | ☐ Running away | ☐ Peer Issues |
| ☐ Stealing | ☐ Impulsive | ☐ Substance Abuse |
| ☐ Hurts animals | ☐ Oppositional/Defiant | ☐ Other: _____ |

Mental Health

- | | | |
|---|---|---------------------------------------|
| ☐ Inability to Regulate Emotions (uncontrollable crying, anger, or shutting down). | ☐ Depressive symptoms | ☐ Suicidal |
| ☐ Health related disease or diagnosis that may impact their Mental Health. | ☐ Self-injurious Behaviors | ☐ Other: _____ |
| | ☐ Eating disorders | |
| | ☐ Sleep disorders | |
| | ☐ Hallucinations/delusions | |

Sexualized Behaviors

- | | | |
|--|--|---------------------------------------|
| ☐ Sexually reactive | ☐ Inappropriate contact with another individual(s). | ☐ Other: _____ |
| ☐ Sexually aggressive | | |

Safety & Risks Needs

- | | | |
|---|--|---------------------------------|
| ☐ Safety plan required | ☐ Has been incarcerated or placed in a residential setting. | ☐ Other: |
| ☐ Involvement with criminal activity | ☐ Drug/Alcohol abuse | |

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

Contact Information

Agency

Contact Information

Agency

Contact Information

YOUTH'S MEDICAL INFORMATION

Primary Care Physician

Phone

Fax

Address

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

☐ Exposure to contagious
disease (MRSA, etc.):

☐ Medical problems

☐ Dietary restrictions

☐ Physical handicap

☐ Infectious disease

☐ Failure to thrive

☐ Any medical restrictions

☐ Does the youth have any
allergies?

Please explain:

Please explain:



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

YOUTH'S EDUCATIONAL INFORMATION

School and Grade

Address

Phone

Teacher

Guidance Counselor

School Social Worker or Clinical Care Coordinator (Please Specify)

Does the Youth have an IEP?

☐ Yes

☐ No

If yes, what classification: _____

Does the Youth have a 504 plan?

☐ Yes

☐ No

If yes, what circumstances: _____

Any educational comments or concerns: _____



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PARENT/LEGAL GUARDIAN

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

Parent/Legal Guardian Name

Relationship to Youth

Phone

Fax

Email

Address

Parent/Legal Guardian Signature

Date