**Today’s Date:**       **Time:**      **pm/am Name of Referring Party:**       **Email:**

**Phone (primary):**       **Child SSN#:**       *\* SSN is required in order to access this service*

***Referring Party Type***

[ ] Corrections [ ] Court or Diversion Program

[ ] School [ ] Behavioral Health Provider

[ ] Physical health care agency/Clinic/Provider [ ] Child Welfare (CFS)

[ ] Substance abuse clinic or provider [ ] Caregiver

[ ] Self (Parent) referred himself or herself [ ] Probation

[ ] Behavioral Health Region (PPP) [ ] Other (Please Specify):

***FPS Referral Eligibility Criteria***

[ ] Child is a legal resident of Nebraska

[ ]  Child/adolescent must be 19 years of age and younger.

[ ]  Child/adolescent is experiencing or will experience a behavioral health crisis

[ ]  At admission, or within 60 days of admission, has diagnosis under the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Developmental Disorders or Psychoactive Substance Use Disorders may be included if they co-occur with the serious emotional disturbance.

**If available, identify diagnosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

[ ]  This pattern has existed for 12 months or longer or is likely to endure for 12 months or longer;

[ ]  Child/adolescent has significant functional impairments as demonstrated by:

[ ]  Functional assessments, behavioral assessments, or other clinical assessment.

[ ]  Or is transitioning back into the community from a long term stay of 3 (three) or more months in a higher level of care.

[ ]  The legal guardian/caregiver of the child/adolescent will experience or is experiencing a behavioral health crisis/challenge that is or has potential to limit their capacity to care for the child/adolescent

[ ]  At risk of needing a higher level of care if support is not provided.

[ ]  Child/adolescent demonstrates a need for support in coordinating treatment/recovery/rehabilitation options in the community.

***Consent***

**Parent/Caregiver Consent and Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the family has worked with particular Advocate in past? [ ]  Yes [ ]  No If so: WHO?

***Family Information***

**Parent(s) Name:**       **Identified Child’s Name:**

**Parent’s Address:**       **City:**       **State: NE Zip:**

**Parent’s Phone (Home):**       **(Cell):**       **(Other):**       **Email:**

**Identified Child’s DOB:**      /     /      **Age:**        **Gender**: [ ]  Boy [ ] Girl [ ] Transgender

* Has the child completed an SBQ-R assessment in the past 6 months? [ ]  Yes [ ]  No
* If, Yes, whom completed this assessment?       Date Completed:       Score:

**Referrals can either be *securely* emailed to Parent to Parent Network:** **chogancamp@parent-parent.org** **or faxed to: (402) 371-7631. Phone numbers: (402) 379-2268 or (877) 226-8819**