**The information included in this form will be distributed to CRCG meeting attendees.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **INFORMATION** | | | | | |
| **Date:** | | **Has a Release of Information authorization been signed?** | | | |
| **Name:** | **DOB:** | **Age:** | **Gender:** | | **Race/Ethnicity:** |
| **Home Address:** | **City:** | **County:** | | | **Zip:** |
| **Parent/Guardian(s) Name:** | | **Relationship:** | | | |
| **Parent/Guardian(s) Primary Phone Number:** | | **Alternative Phone Number:** | | **Email Address:** | |
| **Language of choice:** | | **Parent/Guardian(s) language of choice:** | | | |
| **Living arrangement:** | | **Insurance/medical coverage (if applicable):** | | | |
| **Other people in the home:** | | | | | |
| **Are there any immediate basic needs?** | | | | | |
| **Please list the individual’s strengths:** | | | | | |

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| **REFERRAL INFORMATION** | | | | | | | | | | | | |
| **Referral Source/Agency:** | | | **Name of Representative or Person making referral:** | | | | | | | | | |
| **Phone Number:** | | | **Email Address:** | | | | | | | | | |
| **Primary Referral Reason:** | | | | | | | | | | | | |
| **How would you like the CRCG to help?** | | | | | | | | | | | | |
| **What services and or supports do you think would be most helpful?** | | | | | | | | | | | | |
| **Put an 'X" next to agencies you would like to be present for this staffing. If unknown, leave blank.** | | | | | | | | | | | | |
| **HHSC - Health and Human Services Commission:** | **DADS - Department of Aging and Disability Services:** | | **DSHS - Department of State Health Services:** | | | | | **ADRC - Aging and Disability Resource Center:** | | | | **DFPS - Department of Family and Protective Services or affiliate:** |
| **TDHCA - Texas Department of Housing and Community Affairs:** | **TJJD/TJPC - Texas Juvenile Justice/Probation Commission:** | | **TWC - Texas Workforce Commission:** | | | | | | | | | **LMHA - Local Mental Health Authority:** |
| **TEA/Local Independent School District and/or Educational Service Center:** | **TDCJ - Texas Department of Criminal Justice:** | | **TCOOMMI - Texas Correctional Office on Offenders with Medical or Mental Impairments:** | | | | | | | | | **LIDDA - Local Intellectual and Development Disability Authority:** |
| **Non-agency partners (Family Representatives, Community and Faith-Based Organizations, Non-profit Organizations, etc.):** | | | | | | | | | | | | |
| **EDUCATION INFORMATION (IF APPLICABLE)** | | | | | | | | | | | | |
| **Name of school attending:** | | **Grade:** | | | | | | | **School District:** | | | |
| **Special education?** | | **If yes, diagnosis or reason:** | | | | | | | **Current IQ (if known):** | | | |
| **Services provided by the school:** | | | | | | **Other relevant information:** | | | | | | |
| **For adults - what is the highest grade attended?** | | | | | | | | | | | | |
| **MENTAL/PHYSICAL HEALTH** | | | | | | | | | | | | |
| **Current mental health diagnosis(es):** | | | **Date of Evaluation:** | | | | | | | | | |
| **Current physical health diagnosis(es):** | | | | | | | | | | | | |
| **Current prescribed medication(s):** | | | | | | | | | | | | |
| **CURRENT/PREVIOUS AGENCY INVOLVEMENT** | | | | | | | | | | | | |
| **Agency:** | | | | **Contact:** | | | | | | **Approximate Date:** | | |
| **Services provided:** | | | | | | | | | | | | |
| **Agency:** | | | | **Contact:** | | | | | | **Approximate Date:** | | |
| **Services provided:** | | | | | | | | | | | | |
| **Agency:** | | | | | **Contact:** | | | | | | **Approximate Date:** | |
| **Services provided:** | | | | | | | | | | | | |
| **PLACEMENT HISTORY (IF APPLICABLE) (e.g., residential placement, hospitalization, foster care, boot camp, non-profit, ICF/IID, shelter, relative placement)** | | | | | | | | | | | | |
| **Facility/Agency/Person Name:** | | | | | | | **Dates of Placement:** | | | | | |
| **Reason for Admission:** | | | | | | | | | | | | |
| **Discharge Status/Outcome:** | | | | | | | | | | | | |
| **Facility/Agency/Person Name:** | | | | | | | **Dates of Placement:** | | | | | |
| **Reason for Admission:** | | | | | | | | | | | | |
| **Discharge Status/Outcome:** | | | | | | | | | | | | |
| **Please return this referral form along with a signed Release of Information form, and the following documents (where applicable/available): Psychological and/or Psychiatric Evaluation, School Documentation, Discharge report from placement** | | | | | | | | | | | | |