NEW DIRECTIONS COMMUNITY OUTREACH SERVICES
TAKING THE COMMUNITY IN A POSITIVE DIRECTION
3117 W. Clay Street Richmond, VA 23230 Phone: (804) 447-8419 Fax: (804) 447-8424 www.ndcos.com

New Directions Community Outreach Services
Intensive In-Home Services
Referral Form

Identify Information

Child's Name: _____ DOB:_____ Age:_____

SSN#_____ Gender: _____

Race:_____ Medicaid#:_____

HMO name: _____

Parent/Guardian: _____

Phone: _____

Address: _____City: _____ZIP: _____

Current Problems and Services

Presenting Problems/Risk Conditions:

_____

_____

_____

List present services being received: (in-home counseling, group home, day treatment, outpatient therapy, case-management, other).

Has In-home counseling been received before? Yes No

Eligibility and Documentation (one of these must be checked in order to be eligible for services)

Child meets at least two of the following criteria on a continuing or intermittent basis:

1. Has difficulty in establishing or maintaining normal personal relationship to such a degree that he or she is at risk of hospitalization or out-of-home placement because of conflicts with family or community.
2. Exhibits such inappropriate behavior that repeated interventions by the mental Health, social services, or judicial system is necessary.
3. Exhibits difficulty in cognitive ability such that he or she is unable to recognize personal danger or recognize inappropriate social behavior.

Child must meet at least one of the following

1. Child requires services that are far more intensive than outpatient care to stabilize the child in the family situation.
2. The child's residence as the setting for services is more likely to be successful than a clinic.
3. At least one parent with whom the child is living must be willing to participate in Intensive In-Home Services, with the goal of keeping the child with the family.
4. Child is enrolled in Medicaid.

Please include:

1. Social History (Any background/social history available on client)
2. Copy of Medicaid Card, if available
3. Relevant Testing/Documents, if available (i.e., IEP, psychological, etc

Person making Referral: _____

Phone: _____

Agency: _____

Date: _____

SUBMIT