Broome County Preventive Services Screening / Referral Form – Justice-Involved Youth

Youth NAME: **Youth DOB:**

PURPOSE:	• Screen and facilitate referrals for eligible Youth and Families to appropriate services. • Obtain priority access to OMH Outpatient Clinic.
QUESTIONS & SUBMISSION:	Broome County DSS – Specialized Services Attn: Ronica Smith Ronica.Smith@dfa.state.ny.us Broome County Probation – Family Services Attn: Chantal Brutovsky Chantal.Brutovsky@BroomeCounty.us

SECTION 1 – YOUTH & PRIMARY CAREGIVER INFORMATION

1. Name - Youth	2. Date of Birth - Youth	3. Gender Identity - Youth	4. Date of Referral

5. Name - Primary Caregiver	6. Phone – Primary Caregiver
7. Email – Primary Caregiver	8. Mailing Address Youth/Caregiver
9. Health Insurance – Youth Private Medicaid CIN #: ____________________ Uninsured Unknown	10. Is the YOUTH enrolled in Medicaid-eligible Health Home Care Management? Yes No Unknown *If yes – specify:*

11. School District:

[NOTE: Family & Children's Counseling Services operate satellite clinics at select districts]

SECTION 2 – REFERRAL SOURCE

12. Name	13. Title	14. Agency/Program

15. Email	16. Phone

SECTION 3 – HOUSEHOLD COMPOSITION

17. Enter name & DOB for all **ADULTS** in the household		18. Enter name and DOB for all **CHILDREN** in the household	
Full Name	Date of Birth	Full Name	Date of Birth
a.		a.	
b.		b.	
c.		c.	
d.		d.	
e.		e.	
f.		f.	

SECTION 4 – PRESENTING SITUATION

19. Describe present situation/circumstances that may benefit from Preventive Services.

SECTION 5 – RISK OF OUT-OF-HOME PLACEMENT

20. Detail how the youth is / may be at risk of eminent out-of-the-house placement.

SECTION 6 – OTHER SERVICE PROVIDERS

21. Indicate any other community programs or services involved with the youth/family.

SECTION 7 – MENTAL HEALTH TREATMENT PROVIDER

22. Indicate the Youth / Family ***CHOICE*** of Mental Health Treatment provider:

Family & Children's Counseling Services

Greater Binghamton Health Center

Lourdes Center for Mental Health

No Preference

SECTION 8 – NOTES / MISC. / ADDITIONAL INFORMATION

23. Indicate any details, not otherwise captured in this document, important for the success of this referral:

SECTION 9 – DSS CASE ASSIGNMENT / ROUTING *(DSS internal use only)*

24. Assigned to:	Date:	
25. Immediate Contact Needed?	Yes	No
26. Is *CONNECTIONS* Open?	Yes	No

27. NOTES:

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