Maryland Coalition of Families
Referral Form for Family Peer Support Services

REFERRAL ORGANIZATION INFORMATION			
Referral Date:	**County/Jurisdiction:**	**Name of Person Making Referral:**	
Type of Referral: **____ 1915i (see details below)** **____ TCM (Specify Level _____)** **____ Family Navigation** **____ Other (specify_____)**		**Referring Organization:**	
		Referring Org. Phone:	**Referring Org. Email:**
1915i Details →	**Waiver Enrollment Date:**	**Bundle Auth Start Date:**	**Bundle Auth End Date:**
Has the family ever received support from MCF? ___Y (Name of Family Peer Support Specialist_____) ___ N			

YOUTH & CAREGIVER INFORMATION			
Youth Name:			**Youth DOB:**
Gender: **___ Male** **___ Female** **___ Transgender (M2F)** **___ Transgender (F2M)**	**Race:** **Ethnicity:** **___ Hispanic** **___ Non-Hispanic**	**Insurance:** **____ Private** **____ None** **____ Other** **____ MA (MA #: _____ *required for 1915i)**	
Address (Street, City, State, Zip Code):			
Caregiver's Name:		**Relationship to Youth:**	
Languages Spoken in Home: **Primary:** **Other:**		**Phone(s):**	**Email:**
Does Caregiver have legal custody? ____Y _____ N **If no, please explain:** **Who has legal custody:**			

CLINICAL INFORMATION
Behavioral Diagnoses (please include diagnostic code): **Primary Diagnosis:** **Other Diagnoses:**

Medical Diagnoses (please include diagnostic code):

Primary Diagnosis:

Other Diagnoses:

Risk Factors (check all that apply and add others as needed):

____ Disconnected Youth ____Homelessness ____ Unstable Housing ____ Financial

____ Food Resources ____ Incarcerated Parent(s) ____ Substance Use ____ Mental Health

____ School Concerns _____ Hospitalization ____ Out of Home Placement ____ DSS Involvement

____ Legal System Involvement (___juvenile or ____ adult)

____ Other (please describe):

CURRENT PLACEMENTS	
School Placement: **Grade Level:**	**School Contact Information:**
Residential Placement:	**Residential Contact Information:**
Is Youth in Detention? ____ Y _____ N If yes, where:	
DJS Worker Contact Information:	**DSS Worker Contact Information:**
ADDITIONAL INFORMATION	
Please include any additional information you feel would be useful:	

Please send referral to:

referral@mdcoalition.org or Fax: 410-730-8331

or call 410-730-8267 for more information

Please DO NOT give directly to Family Peer Support Staff

www.mdcoalition.org/referral