MULTNOMAH COUNTY OREGON

Department of County Human Services - Mental Health And Addiction Services Division - Family Care Coordination Team
421 S.W. Oak, Suite 520; Portland, Oregon 97204 Phone 503.988.4161 Fax 503.988.3328

Date: _____

To the referring party:

Thank you for requesting a Level of Care Determination for Integrated Service Array Treatment.

Enclosed is a referral form and checklist for the required supporting documentation. Multnomah County Family Care Coordinators (FCCs) are available to help if needed. Please feel free to call them at 503-988-4161.

The checklist helps make sure all the required papers and signatures are completed and included in your referral packet when you send it to the Family Care Coordination Team (FCCT). We recommend that you check off the items as you complete the packet. We will not be able to make a level of care determination until all packet items arrive. Sending an incomplete packet will delay the process.

The referral packet may be mailed or faxed to:

FCCT Intake
421 SW Oak St., Suite 520
Portland, OR 97204

Fax: 503.988.3328

Once a completed referral packet is received, one of the FCC reviewers will call you to confirm receipt and tell you that the review period has begun.

A decision on the recommended level of care for the referred client will be made within 3 working days of receipt of the completed packet. Prior to this decision, if you are experiencing a crisis, remember that you can call the Multnomah County Crisis Line at 503-988-4888, or call 911.

If you need alternative formats or languages for this application, please contact the FCCT and they will assist you.

Please feel free to call an FCC at 503-988-4161 if you have any questions, problems, or concerns with the referral process.

Sincerely,

Multnomah County Family Care Coordination Team

MULTNOMAH COUNTY OREGON

Department of County Human Services - Mental Health And Addiction Services Division - Family Care Coordination Team
421 S.W. Oak, Suite 520; Portland, Oregon 97204 Phone 503.988.4161 Fax 503.988.3328

Level of Care Determination for Integrated Service Array
Referral Packet Checklist

☐ 1. Completed Referral Form (enclosed)

☐ 2. A signed "Authorization to Release Information" form allowing Multnomah County to exchange information with all referring parties. A separate Authorization Form for each referring agency, community partner, etc. is required. This signature must be from not only the parent/guardian, but from the child if 14 years of age or older.

☐ 3. A comprehensive Mental Health Assessment within the last 60 days that includes a 5-axis diagnosis.

☐ 4. Results of any direct patient observation and assessment of the child subsequent to the referral.

☐ 5. If requesting Psychiatric Residential Treatment Services, a written psychological and or psychiatric evaluation completed within the last 60 days if available.

☐ 6. Information from all referring parties including the school and other mental health agencies currently involved in the care of the youth and family that is pertinent and would assist in the determination process. Documents may include treatment plans, IEPS, school evaluations, Reformation Plans, and previous mental health assessments.

MULTNOMAH COUNTY OREGON

Department of County Human Services - Mental Health And Addiction Services Division - Family Care Coordination Team
421 S.W. Oak, Suite 520; Portland, Oregon 97204 Phone 503.988.4161 Fax 503.988.3328

ISA Level of Care Determination Referral Form

Referring for:
- ☐ Psychiatric Residential
- ☐ Psychiatric Day Treatment
- ☐ Intensive Community-Based Treatment Services (ICTS)

CLIENT IDENTIFYING INFORMATION:

Child's Name: _____ Date of Birth: _____

Current Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Lives With (name and relationship): _____

Sex: ☐ M ☐ F *Ethnicity: ☐☐ Language Preferred: _____

Medicaid #: _____ English Proficiency: ☐ High ☐ Medium ☐ Low

**Marital Status: ☐☐ ***Referral Source ☐☐ Referral Date _____

Reason for Referral:

FAMILY INFORMATION:

Name of Legal Guardian: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Family Monthly Gross Income: $_____

Ages of all family members living on Family Monthly Income: ☐ 0-6 ☐ 7-17 ☐ 18-64 ☐ 65+

Primary Source of Household Income:

☐ Wages ☐ Public Assistance ☐ Other ☐ None ☐ Unknown

**CONFIDENTIAL INFORMATION
NOT FOR RE-RELEASE
VIOLATION OF OAR 179-505
AND CFR 45-164.508**

HEALTH INSURANCE:
☐ VA
☐ Medicaid
☐ Private Insurance
☐ Other Public Asst.
☐ None
OHP: ☐ Verity ☐ Open Card

Name of Medical Provider _____

Address _____

City _____ State ____ Zip _____ Phone: _____

Current Medications: No ☐ Yes ☐ _____

_____

SYSTEM INVOLVEMENT:

Child Welfare: ☐ TC ☐ Voluntary

DHS Worker Name: _____

Address: _____

Phone: _____ Fax: _____

DHS Branch: _____

LEGAL INFORMATION:

☐ Probation ☐ Parole ☐ OYA

PO/OYA Worker Name: _____

Address: _____

Phone: _____ Fax: _____

SCHOOL INFORMATION:

IEP: ☐ Yes ☐ No IDEA Condition: _____

Name of Current School: _____

School Home District: _____

Educational Surrogate Name: _____ Relationship to Client: _____

Current Grade: _____ Is Child/Adolescent Enrolled in School? ☐ Yes ☐ No

Is the Child/Adolescent Currently Employed? ☐ Yes ☐ No

Employment Status: ☐ Employability Factor: ☐

DEVELOPMENTAL DISABILITIES:

DD Worker Name: _____

Address: _____

Phone: _____ Fax: _____

DIAGNOSIS:

Axis I _____

_____

_____

Axis II _____

Axis III _____

Axis IV _____

_____

_____

Axis V Current GAF: (17+ years) ☐ Current CGAS: (4-16 years) ☐ Highest GAF/CGAS in past year: ☐

Diagnosis from Name/Agency: _____ Date: _____

Eligibility Code: ☐☐

DOCUMENTATION ATTACHED:

- ☐ Mental Health Assessment
- ☐ Treatment Plan
- ☐ Progress Note
- ☐ Psychological Evaluation (if available)
- ☐ Psychiatric Evaluation
- ☐ Other, please specify: _____

_____

_____ _____

Signature of Referral Source Date

CONFIDENTIAL INFORMATION
NOT FOR RE-RELEASE
VIOLATION OF OAR 179-505
AND CFR 45-164.508

Referral Source:

00	Unknown	**08**	Support Programs for Children (Child Welfare)	**38**	Self Help Groups (non-A&D)
04	Developmental Disabilities	**31**	Primary Care Provider/Specialist/Phys Hlth Provider	**48**	Fully Capitated Health Plan
05	School	**32**	Self	**49**	MHO
06	Other Comm. Agencies (e.g. Alcohol, Drug)	**33**	Family/Friend	**99**	Other
07	Support Programs for Adults (TANF/Food Stamps)	**37**	Youth Service Agencies, Centers, or Teams		

CPMS Ethnicity:

01	White (Non-Hispanic)	**05**	Asian	**09**	Other Hispanic
02	Black (Non Hispanic)	**06**	Hispanic (Mexican)	**10**	Southeast Asian
03	Native American	**07**	Hispanic (Puerto Rican)	**11**	Other Race/Ethnicity
04	Alaskan Native	**08**	Hispanic (Cuban)	**12**	Hawaiian/Other Pacific Islander

Eligibility Codes:

04 Severe & Persistent Mental Illness /SE Disorder
16 Priority One Client
17 Priority Two Client
18 Priority Three Client

Living Arrangement:

01	Alone	**05**	Institutions
02	Spouse	**06**	Friend or Other
03	Parents, Relatives	**21**	Treatment Foster Care
04	Non-Relative Foster Home	**97**	Homeless/Shelter

Marital Status:

1	Never Married	**4**	Divorced
2	Married	**5**	Separated
3	Widowed	**6**	Living as Married

Health Insurance:

05 VA
08 Medicaid
11 Private Insurance
12 Other Public Asst.
13 None

Employment Status:

1	Full-Time 35+ hrs
2	Part-Time 17-34 hrs
3	Irregular – less than 17 hrs
4	Not employed but has sought work
5	Not employed and has NOT sought work

Employability Factor:

0 Employable or working now	5 Incarcerated
1 Student	6 Seasonal worker
2 Homemaker	7 Temporary layoff
3 Retired	9 Unknown
4 Unable for phys. or psych. reasons	

FCCT Referral Form CPMS Codes.doc