CHAMPIONS
FOR CHILDREN'S MENTAL HEALTH

Referral for Family Support Services

To make a referral, please complete ***AND SIGN*** this form and send to our referral coordinator at:

Email: Referrals@ChampionsDe.com or Fax: 302-883-3273
Phone: 302-724-7229 | 21 W. Clarke Ave, Suite 1600, Milford DE 19963

Child's Information

Child Name: _____ DOB: _____

Gender: ___Male ___Female Resides with: _____

Parent/Legal Guardian Information

Parent/Guardian Name: _____ Phone: _____

Relationship to child: _____ Alternate Phone: _____

Address: _____

Email Address: _____

Insurance Information

Medicaid? ___Yes ___No Medicaid MCO: _____

MCO ID#: _____

Private Insurance: _____ ID# _____

Referral Agent Information – Professional Completing this Referral

Name: _____

Type of Professional License: _____
(physician, nurse practitioner, physician assistant, licensed psychologist, LCSW, LPCMH)

Agency/Practice: _____ Phone: _____

Email: _____

Clinical Information

Current Diagnosis:	DSM-5 Code:	Diagnosed by:

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Reason for Referral to Family Support Services: _____
Which of the following support needs are included in your treatment plan for this family? (One or more will be necessary for insurance coverage)

○ Outreach and Information	○ Advocacy and Empowerment
○ Community Connections and Natural	○ Bridging Services
○ Caregiver Psychoeducation	○ Caregiver self-care
○ Navigation of _____ system	○ Family Goal Setting

_____ _____

*****Referral Agent/Provider Signature***** Date

Parent/Legal Guardian Consent

As the legal guardian of this child, I understand that we have certain rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including right to privacy regarding the child's protected health information, including information shared in this referral.
I agree for the "Referral Agent" listed above to complete this form and share the information with Champions for Children's Mental Health for the purpose of referring my child for Family Peer Support Services. I *further agree* that Champions for Children's Mental Health Family Support Services staff may contact and speak with the listed referral agent in order to coordinate the referral.

This consent to share information will be effective for 6 months from the date of my signature below, or until _____. I understand that I have the right to revoke this consent at any time and no further information will be shared as of that time.

_____ _____

Parent/Guardian Signature Date

_____

Printed Parent/Guardian Name