Eastern Virginia Advance Care, LLC
The Leader in Professional Healthcare

Intensive In-Home Service Referral

Client Information (Please Print)

Client Name: _____ Birth Date: _____ (mm/dd/yyyy) Gender: **M/F**

Social Security #: ____-_____-_____ Medicaid #: _____

Parent/Guardian: _____ Contact Number: _____

Address: _____

PCP Name/Number: _____

Eligibility Criteria / Must meet at least two of the following:

- Does the client have difficulty due to a mental, behavioral, or emotional illness in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or out-of-home placement because of conflicts with the family/community?
  - "Out of home" is defined as: Level A or B group home, regular foster home, treatment foster care placement, level C residential facility, emergency shelter, psychiatric hospitalization, juvenile justice/incarceration placement
- Does the client exhibit such inappropriate behavior due to mental, behavioral, or emotional illness that repeated interventions by the mental health, social services, or judicial system are necessary?
- Does the client exhibit difficulty in cognitive ability due to mental, behavioral, or emotional illness such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior?

Click the box next to all that apply:

Difficulty with basic functioning		Advanced Functioning Skills		Cognitive functioning	
☐	Aggression / Bullying	☐	Defiance	☐	Gang Violence
☐	Peer Relationships	☐	Involvement with courts	☐	Parent / Child Relationships
☐	School Failure / Truancy	☐	Depression	☐	Lack of Family Structure
☐	Peer Violence	☐	Profane / Abusive Language	☐	Poor Coping Skills
☐	Substance Abuse	☐	Teen Parenting	☐	Juvenile Arrest

Additional Serviceable Problems

Referral Accepted by: *(Clinical approval)* ***Name:*** _____

Referral Source (Contact Person)**:** _____

Phone: _____ **Date:** _____