STATE OF NEW HAMPSHIRE
Department of Health and Human Services
Division for Behavioral Health, Bureau for
Children's Behavioral Health

Form CBH0008
PD25-03

This tool should be completed prior to consideration for the Children's System of Care Tier 4 Services and shall accompany the Comprehensive Assessment for Treatment (CAT) referral. Referrals coming from the community shall send this tool and the referral to BCBH. The CME shall send this tool and the referral directly to Maximus.

Questions		**Weighted 'Score'**	
Date of Screener: Date	**Youth Initials:** Initials	Yes = 1	No = 0
Has the child and family both consented to the referral? *i.e. the child has expressed that they are willing to go to residential treatment*		☐	☐
Has the youth and family engaged and exhausted community based resources? *Including but not limited to **Children's System of Care: Tier 2** services such as Intensive in-home services offered by the Community Mental Health Centers, Community Based Voluntary Services (CBVS), etc. or **Tier 3** services such as Fast Forward, Intensive In-Home/Individual Service Option (ISO) or other intensive in-home programs*		☐	☐
Has the youth been to an emergency hospital (or Rapid Response) for psychiatric evaluation in the last 12 months?		☐	☐
Has the youth been admitted to a psychiatric hospital in the last 12 months? *i.e., Hampstead Hospital, Brattleboro Retreat, Anna Jaques, etc.*		☐	☐
This request is based on the youth's clinical need for treatment at a residential setting, not based primarily on a family need (housing, etc.)		☐	☐
A supervisor at your agency has approved this referral for a CAT. *		☐	☐
Subtotal			
The Subtotal must equal 6 and yes to all answers from questions 1-6 being in order to proceed with Referral for a CAT. Unless it is a parent referral and a supervisor is not required. *		☐ **Make Referral**	☐ **Do not make referral**

Additional Information

Is this a Post-Adopt Case ☐ **YES** if yes please list agency ☐ **NO**	Adoption Agency
Is the child younger than 17.5 ☐ **YES** ☐ **NO** BCBH EOT is intended to be completed and returned home prior to a child's 18th birthday	Age
If DCYF is involved, was DCYF consulted about the referral? ☐ **If YES,** please list the JPPO or CPSW ☐ **If NO**, please reach out to DCYF before submitting referral ☐ **If NA,** move on (there is no DCYF (CPS/JJS) involvement) If there is an open DCYF (JJS or CPS) court case the referral should be made through DCYF and should not be a community referral.	JPPO or CPSW Name and Contact
If the youth has a developmental disability is the area agency involved? ☐ **If YES,** please be sure the Area Agency is aware of the referral and list the AA contact ☐ **If NO,** if the Area Agency is not involved, please begin by contacting the Area Agency for resources if necessary ☐ **If NA,** move on (the youth does not have a developmental disability)	Area Agency Assigned and Contact
Does the youth have an IEP ☐ **If YES,** please make sure the district is aware of the referral for the CAT and please list the district of liability ☐ **If NO**, has the IEP referral process begun and if not this must begin if appropriate ☐ **If NA,** move on (there is no special educational need)	District of Liability

If the youth does not meet the criteria for referral and there is a compelling argument for a CAT referral please reach out to BCBH to discuss the individual scenario DHHS: CAT Referral CATReferral@dhhs.nh.gov .