COMMUNITY RESOURCE COORDINATION GROUPS
STAFFING REFERRAL FORM
____________COUNTY CRCG

The information included in this form will be distributed to CRCG meeting attendees.

INFORMATION

Date:			Has a Release of Information authorization been signed?	
Name:	DOB:	Age:	Gender:	Race/Ethnicity:
Home Address:	City:	County:		Zip:
Parent/Guardian(s) Name:		Relationship:		
Parent/Guardian(s) Primary Phone Number:		Alternative Phone Number:	Email Address:	
Language of choice:		Parent/Guardian(s) language of choice:		
Living arrangement:		Insurance/medical coverage (if applicable):		
Other people in the home:				
Are there any immediate basic needs?				
Please list the individual's strengths:				

REFERRAL INFORMATION

Referral Source/Agency:	Name of Representative or Person making referral:
Phone Number:	Email Address:
Primary Referral Reason:	
How would you like the CRCG to help?	
What services and or supports do you think would be most helpful?	

Put an 'X" next to agencies you would like to be present for this staffing. If unknown, leave blank.

HHSC - Health and Human Services Commission:	DADS - Department of Aging and Disability Services:	DSHS - Department of State Health Services:	ADRC - Aging and Disability Resource Center:	DFPS - Department of Family and Protective Services or affiliate:
TDHCA - Texas Department of Housing and Community Affairs:	TJJD/TJPC - Texas Juvenile Justice/Probation Commission:	TWC - Texas Workforce Commission:		LMHA - Local Mental Health Authority:
TEA/Local Independent School District and/or Educational Service Center:	TDCJ - Texas Department of Criminal Justice:	TCOOMMI - Texas Correctional Office on Offenders with Medical or Mental Impairments:		LIDDA - Local Intellectual and Development Disability Authority:
Non-agency partners (Family Representatives, Community and Faith-Based Organizations, Non-profit Organizations, etc.):				

EDUCATION INFORMATION (IF APPLICABLE)

Name of school attending:	Grade:	School District:
Special education?	If yes, diagnosis or reason:	Current IQ (if known):

Services provided by the school:	Other relevant information:

For adults - what is the highest grade attended?

MENTAL/PHYSICAL HEALTH

Current mental health diagnosis(es):	Date of Evaluation:

Current physical health diagnosis(es):

Current prescribed medication(s):

CURRENT/PREVIOUS AGENCY INVOLVEMENT

Agency:	Contact:	Approximate Date:
Services provided:		
Agency:	Contact:	Approximate Date:
Services provided:		
Agency:	Contact:	Approximate Date:
Services provided:		

PLACEMENT HISTORY (IF APPLICABLE) (e.g., residential placement, hospitalization, foster care, boot camp, non-profit, ICF/IID, shelter, relative placement)

Facility/Agency/Person Name:	Dates of Placement:
Reason for Admission:	
Discharge Status/Outcome:	
Facility/Agency/Person Name:	Dates of Placement:
Reason for Admission:	
Discharge Status/Outcome:	

Please return this referral form along with a signed Release of Information form, and the following documents (where applicable/available): Psychological and/or Psychiatric Evaluation, School Documentation, Discharge report from placement