PerformCARE

Child/Adolescent Services
RTF/CRR-HH Provider referral feedback form

Date_____
When complete, please fax this form back to the referring Agent at the fax number indicated here;
Referring Agent:
☐PerformCare fax: 1-888-987-5828
☐TCM fax: _____ TCM Phone: _____

TCM Name: _____

Member Name: _____ **MAID:** _____

Provider Name: _____ **Site Location:** _____

A. Accepted
☐**Site/Cottage Accepted into:** _____
☐**No current opening on waiting list**
☐**Targeted admission date of** _____

B. Member <u>is not</u> a candidate for our program for the following reasons.

1. Capacity
☐ No immediate capacity, even though member is appropriate for placement.
☐ Openings available for member approximately _____.

2. Age ☐ Too young ☐ Too old

3. Gender ☐ Male-only beds ☐ Female-only beds

4. Diagnosis
☐ Specify which diagnosis and why.

_____

_____

5. Presenting Behaviors (identify specific behaviors below)
☐ Too aggressive ☐ Sexual Reactive ☐ Sexual Offending ☐ Self-Injurious Behaviors ☐ Fire Setting Behaviors
☐ Other (please be specific)

_____

_____

6. Other
☐ Please specify_____

7. No appropriate homes (CRR only)
☐ No homes are available within the agency
☐ Will continue search if openings become available ☐ Referral is closed
☐ Male only beds ☐ Female only beds
☐ Homes available, but none able to meet member's needs (please give specific reasons below):

_____

RTF/CRR-HH Staff member Name: _____ **Date:** _____