CALVERT COUNTY HEALTH DEPARTMENT
LOCAL BEHAVIORAL HEALTH AUTHORITY
P.O. Box 980
Prince Frederick, Maryland 20678

Laurence Polsky, MD, MPH, F.A.C.O.G
Health Officer

Andrea McDonald-Fingland LCSW-C
LBHA Director

STATE OF MARYLAND

Phone (410) 535-5400
Washington Area (301) 855-1353
Baltimore Area (410) 269-1051
Fax (410) 535-5285
www.calverthealth.org

CTI Referral Form

Critical Time Intervention

Please Note: All fields in this referral form are required to be completed to the best of your ability in order to be considered complete.

Today's Date: ________________

Client's Name: ____ Date of Birth: _________________

Client's Age: ___________ S.S.N. #: ________________________ Phone: ______________________

Full Address: ____

Referral Source/Name: ____________________________Title: ______________________________

Email Address: ____________________________________ Phone #: ________________________________

If available, please provide a recent evaluation, treatment plan, or discharge summary, signed by a licensed mental health professional or physician, documenting applicants' diagnoses. Please include the professionals' contact information.

____

What is the reason for today's referral? Please provide an explanation of need for this applicant, if possible, provide background information relevant to the situation, and the reason for the referral.

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Is the applicant:

Currently housed? If so, what area do they live in? Zip code?

____

____

How long has the applicant been currently housed? ______________________

Behavioral Health History:

Does the applicant have a mental or behavioral health diagnosis? If so, please describe below. What services has the client participated in?

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____

Client's Financial Status:

- Medical Assistance M.A. # ________________________
- Medicare M.C. # ________________________
- SSI $ Amount: ________________________
- SSDI $ Amount: ________________________
- Other Income/Benefits (Specify & Include $ Amount) ________________________

(Signature's Below:)

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______________________________________ ____________________________

Applicant's Signature: **Today's Date:**

______________________________________ ____________________________

Referral Source's Signature: (If different from above) **Today's Date:**

Coordinator Use Only:

Date Referral Received: _____/_____/_______ **Coordinator Initials: _____________**

Referral Received via:

☐ **Email**

☐**Fax**

☐**Hard Copy Delivered**

Date Initial Client Contact Made: _____/_____/_______ **Contacted Via: _____________________**
Second Contact Attempt Made: _____/_____/_______ **Contacted Via: _____________________**
Third Contact Attempt Made: _____/_____/_________ **Contacted Via: _____________________**
Fourth Contact Attempt Made: _____/_____/_______ **Contacted Via: _____________________**
Final Contact Attempt Made: _____/_____/_______ **Contacted Via: _____________________**

NOTES:

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