Family ID #

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Independence Rising Peer Support Referral

Family Information

Parents Name______________________________________ Childs Name____

Address_______________________________________City______________________State____NE____Zip______________

Phone Number___________________________________ Email____

Childs DOB_________________________________ Age___________ Gender _________________________________

Medicaid Provider_____________________ Medicaid Number__________________ Social Security #__________________

❖ Has the child completed an SBQ-R assessment in the past 6 months_______________________________________

date complete__________________ score_________ Who completed assessment ___________________________

FPS Referral Eligibility Criteria

- ☐ Child is a legal resident of Nebraska
- ☐ Child/adolescent must be 19 years of age or younger
- ☐ Child/Adolescent is experiencing or may experience a behavioral health crisis.
- ☐ At admission or within 60 days of admission, has a mental health diagnosis under the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association Developmental Disorders or Psychoactive Substance Use disorders may be included if they co-occur with the serious emotional disturbance.

If available, identify diagnosis____

- ☐ This pattern has existed for 12 months or longer or is likely to endure for 12 months or longer;
- ☐ Child/adolescent demonstrates significant functional impairments due to their behavior health diagnosis as demonstrated by:
- ☐ Functional assessments, behavioral assessments, or other clinical assessments
- ☐ Or is transitioning back into the community from a long term stay of 3 or more months in a higher level of care.
- ☐ The legal guardian/caregiver of the child/adolescent is experiencing challenges that are limiting their capacity to care for the child/adolescent
- ☐ At risk of needing a higher level of care if support is not provided
- ☐ Child/Adolescent demonstrates a need for support in coordinating treatment, recovery, rehabilitation options in the community.

Referring Party Type

☐ Corrections	☐ School
☐ Physical Health care agency/clinic/provider	☐ Substance abuse clinic or provider
☐ Self (parent) referred himself/herself	☐ Behavioral Health Region (PPP)
☐ Court or Diversion Program	☐ Behavioral Health Provider
☐ Child Welfare (CFS)	☐ Caregiver
☐ Probation	☐ Other_________________________________

Name of Referring Party______________________________ Date ____________________ Time_____________________

Phone #__________________________Email____

Consent: Parent/Caregiver Consent Signature____

REFERRALS CAN BE EMAILED or Faxed to 308-708-2397 FAME@irnebraska.org

Deb Turner dturner@irnebraska.org 308-746-4728 OR Mary Stockwell 308-641-8449 mstockwel@irnebraska.org

FPSS Assigned: ____Date: _____________________

Supervisor Signature____

☐**Family Navigator** ☐**Family Peer Support** ☐**CFS** ☐**Peer Link**

Revised 07/19/23