TEXAS Health and Human Services

Form 2823
October 2021-E

Residential Treatment Center (RTC) Project

Local Mental and Behavioral Health Authority Referral

Directions: Complete this form with the family. The Local Mental Health Authority (LMHA) and Local Behavioral Health Authority (LBHA) must submit this completed form via secure email to RTCProject@hhs.texas.gov.

Child's Information

Child's Name:			Date of Referral:
Date of Birth:	Gender:	County:	Social Security No.:
Medicaid ID:		Clinical Management for Behavioral Health Services (CMBHS) No.:	

LMHA/LBHA Information

LMHA/LBHA Name:	
RTC Liaison Name:	Email:
LMHA/LBHA Caseworker Name:	Email:

Legally Authorized Representative Information

Legally Authorized Representative:			Area Code and Phone No.:
Address:	City:	State:	ZIP Code:
Details:			

Living Situation

Where is the child currently residing?

Are there safety concerns for other minors in the home? ◯ Yes ◯ No

Has the child been previously removed from the home due to safety concerns? ◯ Yes ◯ No

Is the family's goal reunification? ◯ Yes ◯ No

Provide a brief summary of child's current living situation. **Note**: Include any steps the legally authorized representative has taken to address safety concerns regarding other minors in the home and any additional concerns regarding family stressors.

Department of Family and Protective Services (DFPS) Involvement

Is there current or prior family history of involvement with DFPS or family court? ◯ Yes ◯ No

Was the child adopted in the state of Texas? ◯ Yes ◯ No

Is the legally authorized representative working with DFPS or Texas Juvenile Justice Department (TJJD) to seek placement in an RTC? ◯ Yes ◯ No

Provide a brief summary of DFPS or TJJD involvement:

Developmental and Mental Health History

Diagnoses:

Child's IQ:

Is the child participating in intellectual or developmental disability or autism services? ◯ Yes ◯ No

Is the child currently receiving mental health services? ◯ Yes ◯ No

What is the child’s current authorized local of care?

Does the child have a history of self-harm? ◯ Yes ◯ No

Does the child have a history of involvement with the TJJD? ◯ Yes ◯ No

Has the child experienced a psychiatric hospitalization within the past two years? ◯ Yes ◯ No

If yes, how many hospitalizations has the child experienced within the past two years?

Does the child have a history of placement in an RTC? ◯ Yes ◯ No

Is the child receiving special education or Section 504 services? ◯ Yes ◯ No

Has the child been referred to the local community resource coordination group (CRCG)? ◯ Yes ◯ No

Has the child been referred to the Waco Center for Youth? ◯ Yes ◯ No

Provide a brief summary of child’s mental health history. **Note**: Include a summary of any out-of-home placements, family and individual participation in LMHA/LBHA services, any substance use concerns or treatment, recommendations from any CRCG staffing, and any reasons for termination or refusal of services.

Brief Narrative

Provide a brief case summary outlining the child’s risk for relinquishment and reason for referral.

Required for Emergency Eligibility Referrals Only

By signing below, as the LMHA/LBHA children’s mental health director, this affirms I reviewed this request and have determined this child is at imminent risk of relinquishment to DFPS.

Children’s Mental Health Director Signature ______________ Date ______________

Required for All Referrals

By signing below, as the RTC liaison, this affirms I reviewed this request and have found no concerns of abuse or neglect.

RTC Liaison Signature ______________ Date ______________

HHSC Official Use Only – State Office Emergency Eligibility Determination

Received by:		**Date:**
◯ Authorization of Emergency Eligibility		◯ Denial of Emergency Eligibility
Justification:		
Program Manager:	Title:	Date: