Send completed form to the ECMH Coordinator at (Fax) 216-432-5037 or Mail to: ECMHReferrals@jfs.ohio.gov
Please call (216) 698-3553 with questions or for more information.

Early Childhood Mental Health Request for Services -- Cuyahoga County

Children Ages 0 to 6

Today's Date:

Child's Age: *Years* *Months*

Child's Name:

Child's Sex:

Child lives with (Name)

Relationship:

Person with Custody:

Child's Soc. Security #

Medicaid #

Child's Birth Date:

CONTACT INFORMATION:

Phone # Ext:

Alternate Phone # Ext.

Address:

City:

Zip:

Family Availability:

REASON FOR REFERRAL: (Check all that apply)

Sleeping/Eating/Soothing concerns
Sad or anxious behaviors
Abuse / Trauma
Recent or at Risk for Disruption

Problems with Attention/Focus
Attachment / Bonding Concerns
Challenging Behav. in Classroom/Daycare
Regression / Loss of Skills

Aggressive Behaviors
Suspected Sexual Abuse/Concerns
Withdrawn / Unresponsive
Loss of Caregiver

Other

REFERRAL TYPE:

Name/Title of Person Providing Referral**:**

Phone #

E-mail

To be Completed by Parent or Guardian: By signing below, I consent for the above information to be shared with one or more community agency/service for the purpose of facilitating a referral for Early Childhood Mental Health Services or for accompanying resources to help my family.

Printed Name:

Signature:

Date:

Please Note: Parent or Guardian Signature must be obtained to process referral

Referral Outcome / Coordinator Notes:

FOR OFFICE USE **Referred for:** **Treatment** **Consult** **Emergency Response** **Other**

Agency: **ACC AWC BB CRCC DCFS GSO PEP CENTERS MT** ______