IOWA HHS

Iowa Department of Health and Human Services

Complex Youth Care Assessment Referral

Youth's Information			
Name:	DOB:	Sex:	Medicaid State ID:
Legal Parent/Guardian	Phone:		
Youth's Current Address:			
Youth's Current Caregivers:	Phone:		

Placement Type:

- ☐ Home with Parent(s)
- ☐ Relative/Kin Placement
- ☐ Hospital
- ☐ Family Foster Care
- ☐ Shelter
- ☐ MHI
- ☐ Qualified Residential Treatment Program (QRTP)
- ☐ Supervised Apartment Living (SAL)
- ☐ Medicaid-funded Placement (PMIC, ICF/ID, RBSCL)

Referring Worker Information (HHS)		
Name:	Email:	Phone:
IHH Care Coordinator Information (if applicable)		
Name:	Email:	Phone:
MCO/CBCM Information (if applicable)		
Name:	Email:	Phone:

Reason for referral (check all that apply) and provide explanation

- ☐ Unclear health status:
- ☐ Mood or anxiety symptoms:
- ☐ Disruptive behavior symptoms:
- ☐ Unusual/odd behaviors present over time (not on an isolated basis):
- ☐ Problems with eating/growth:
- ☐ Concerns for harm to self or others on a chronic basis:
- ☐ Poor adaptation to living situation changes:
- ☐ Poor academic or behavioral performance:
- ☐ Other:

Attach all available supporting documentation.