

How to complete the ITM Referral Form

Quick Tip: Form must be typed & password protected for submission

Referring Service Area Information

Referral Service Area/Program: Which DHHS program are you referring from or have a contract with?
*If a contract program, form should be completed by DHHS contract monitor.

Date: Date referral form is completed

DHHS Employee Referring: Name of DHHS Employee making the referral

Phone: Direct phone number of DHHS Employee making referral

E-Mail: County e-mail address of DHHS Employee making referral

Supervisor: Referring DHHS Employee's current supervisor

Phone: Direct phone number of Supervisor

E-Mail: Direct E-Mail address of Supervisor

Lead Case Manager: If a contract program, fill in name of the lead case manager.

Phone: Direct phone number of lead case manager

E-Mail: E-mail Address of lead case manager

Reason(s) for Intensive Team Meeting: Describe challenges experienced requiring ITM

ITM Case Criteria For Entry:

- Intensive and complex needs
- Multiple needs that involve 2 or more systems or program service areas
- Client is stuck and unable to progress toward achieving goals in one or more of the five domains: Education, Employment, Housing, Health Care & Permanent Connections
- Less intensive interventions have been tried

Meeting Goal(s): What is the goal(s) for the client's care?

- 1. Have you discussed this case with your supervisor?** Has this case been discussed with your Supervisor? If yes, what was the outcome? If not, why not?
- 2. What is this meeting type?:**
 - a. Initial: First ITM
 - b. Follow Up ITM: An initial ITM was held and a follow up is being requested
 - c. Barrier Resolution Meeting: Previous ITM's completed, now requesting more intensive including senior level staff and facilitated by Service Integration Coordinator
- 3. Will the client participate in meeting?** Will the client be attending ITM? If no, explain why not.

- a. **Will referring staff be providing or coordinating transportation for the client and/or family to attend?** Choose to acknowledge that responsibility of coordinating transportation for the client/family members to attend ITM is that of referring staff.
- 4. If providers need to confer prior to the client's arrival. Indicate how much time is needed:** Choose a block of time if applicable for providers to meet prior to client's arrival
- 5. Will a telephone conference line be needed for the meeting?** Will any identified participant need to call in to the meeting?
- 6. Is an interpreter needed for this meeting?** Does the client or another identified participant need a language interpreter to fully participate in ITM? Indicate which language including ASL.
- 7. Is there a signed release(s) in place for all providers?** If referrer has obtained signed release from client, please attach to e-mail. If no release is in place, explain why one has not been obtained. *Coordinator is unable to schedule meeting or contact service providers without written indication that the client has signed the consent form that will allow service providers to share information both at the ITM and after for case planning and delivery.
- 8. ITM Scheduling:** Choose 3 potential Thursday dates and times for your ITM to be held at 401 Hungerford Drive, Rockville, MD 20850
- 9. ITM Location:** Are you requesting the ITM to be held at a different location than 401 Hungerford?
 - a. Provide the full address, room number and directions if necessary as well as any parking instructions for the requested ITM site
 - b. Indicate if the room has a phone that can be used for participants calling in to the conference line

Client Information

Name (First, Last): First and Last name of client

Date of Birth: Client's date of birth MM/DD/YYYY

Age: Current age of client

Gender: Client's gender

eICM ID #: Assigned eICM id number

Diagnosis (if applicable): List all medical and psychiatric diagnoses

Current/Past Services (check eICM for comprehensive list)

Program: What DHHS program is client involved in/has been involved with?

Contact Person: Who is the client's case manager/point of contact for program?

Is staff attendance required: Is the presence of this individual relevant for the ITM?

E-Mail: E-Mail address of program's contact person

Phone: Direct phone number of program's contact person

Household Information

Name (First, Last): First and Last name of household member

Relationship to client: How is client connected to the individual?

Age: Current age of household member

Lives with client: Does this household member and client live in the same household?

Should attend: Is the presence of this individual relevant for the ITM?

Services Household Member Receives: List all DHHS services member is receiving

Language Preference: What language including English does the member prefer for communication?

E-mail: Current e-mail address for member

Phone: Current phone number for member

***Referring staff confirms that any family/household who should attend ITM will be invited by the referring staff:** Choose to acknowledge that the responsibility of inviting family/household members to the ITM is that of referring employee

Additional Service Providers/Other Contacts to be Invited

Name (First, Last): First and Last name of additional persons appropriate to the client's ITM

Service Area/Program/Partner/Relationship to Client: Role of individual to client

E-mail: Current e-mail address of individual

Phone: Direct phone number of individual

Brief Case History

One page maximum of client's detailed case history. This should "tell the client's story" to those reading which allows an understanding of the needs, challenges and goals of the meeting.

How to Submit:

1. Review that each question is answered
2. Password Protect Document:
 - a. Click the File tab.
 - b. Click Info.
 - c. Click Protect Document, and then click Encrypt with Password.
 - d. In the Encrypt Document box, type a password, and then click OK.
 - e. In the Confirm Password box, type the password again, and then click OK.
*If you don't remember your password, Microsoft can't retrieve forgotten passwords.
3. Attach form & release to e-mail documents
4. Send referral & completed release to DHHS.PACS@montgomerycountymd.gov
5. Send password to document in a separate e-mail to DHHS.PACS@montgomerycountymd.gov