Community Integrated Health Services

Student Threat Assessment Care Coordinator (S-TACC) Referral Form

S-TACC stands for School-Threat Assessment Care Coordination. A school superintendent can request S-TACC to monitor a child who has been expelled due to having made targeted threats of violence toward the school or community. S-TACC sees the child in the home and communicates status with the Safety Team. The S-TACC Team consists of a lead S-TACC care coordinator who works directly with the school Safety Team.

Instructions:

- Please complete this referral form and attach a copy of your insurance card and any additional information if available.
- Submit this referral form and any attachments in person or via:
  - Email Scheduling@cihealthservices.com
  - Fax: (844) 554-3370 or (360) 748-4480
  - Postal Mail (see last page for mailing addresses.)
- CIHS will confirm receipt of the referral and will contact you within one business day of receipt of request.
- Check the county where you anticipate services being provided:

  ☐ Cowlitz ☐ Grays Harbor ☐ Lewis ☐ Pacific ☐ Wahkiakum

- How did you hear about us? _____

Referent Information

Are you Self Referring? ☐ Yes ☐ No (if yes skip to next section)

Agency Name:_____Date:_____

Contact Name:_____Phone:_____

Contact Email Address: _____

Individual Requesting Services

First & Last Name and Avatar ID:_____Date:_____

Birthdate:_____Preferred Gender Pronoun: _____

Home Address: _____

City:_____State:_____Zip:_____

Email Address: _____

Cell Phone:_____Home Phone: _____

School Attending: _____

If the Youth is 13 years of age or older, they can legally consent to behavioral health treatment on their own. If the youth does not wish to have Medicaid Insurance statements or other treatment-related correspondence sent to the above mailing address please mark this box: ☐

If the Youth is 13 years of age or older; does that Youth want their parent/guardian to have knowledge of the referral: ☐ Yes ☐ No

Parent/Guardian Information

First & Last Name: _____

Relationship:_____Phone: _____

First & Last Name: _____

Relationship:_____Phone: _____

First & Last Name: _____

Relationship:_____Phone: _____

Reason for Requesting Services

Examples: homicidal and/or suicidal ideations, substance use/abuse, depression, trauma stressors, multi-system involvement, family functional difficulties, etc.

Diagnosis (If Known) and/or Symptoms

Community Integrated Health Services Mailing Addresses:
Cowlitz County: 1128 Broadway, Longview, WA 98632
Grays Harbor: 110 W Market St, Suite 205, Aberdeen, WA 98520
Lewis County: 1707 Cooks Hill Road, Centralia, WA 98531
Pacific County: 335 Third Street, Raymond, WA 98577
Pacific County: 152 First Ave North, Ilwaco, WA 98624
Wahkiakum County: 427 Columbia Street, Cathlamet, WA 98612
Website: www.cihealthservices.com

For Office Use Only:

Received By:_____ Date:_____

Received Via: ☐ Email ☐ Fax ☐ Mail ☐ In-Person ☐ Other_____

Provider One # _____