

REFERRAL FOR CHILD AND YOUTH CASE MANAGEMENT SERVICES

PROGRAM REQUESTED:

- Supportive Case Management Intensive Case Management Home and Community Based Services Waiver

Referrals for any residential program licensed by the New York State Office of Mental Health, including Family Based Treatment, Teaching Family Homes, Community Residences, and/or Residential Treatment Facilities, must also be reviewed by the Single Point of Entry. For information on how to make a referral to one of these programs, please call 792-7143.

CLIENT INFORMATION:

Name: _____ Date of Referral: _____

Address: _____ City, State, Zip: _____

Phone: _____ Sex: _____ DOB: _____ School: _____

Social Security #: _____ Medicaid #: _____ Other Insurance: _____

Mother (include name, address, phone): _____

Father (include name, address, phone): _____

Siblings (include ages): _____

Current guardian/custodial adult: _____

Lives with: Parent(s) Guardian Other: _____

Emergency contact: _____ Relationship: _____ Phone: _____

Please check all that apply:

- Functional limitations in the areas indicated: Self-care Family life
- Social relationships Learning ability Self-direction
- Met criteria for a rating of 50 or less on the Children’s Global Assessment Scale in the past year
- Meets criteria for a rating of 50 or less on the Children’s Global Assessment Scale currently
- Experienced one of the following in the last 30 days:
 - Serious suicidal symptoms or other life-threatening destructive behaviors;
 - Significant psychotic symptoms; and/or
 - Behavioral problems causing a risk of personal injury or significant property damage.

Referral Source: _____ Name: _____ Relationship: _____

Address: _____ Phone: _____ Fax: _____

Reason for referral at this time (please state specifically how these services will benefit the child or youth): _____

PSYCHIATRIC INFORMATION:

Clinical Treatment Provider: _____ Phone: _____

Therapist: _____ Psychiatrist: _____

Diagnosis : Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Medications (please list dosage and attach additional sheets if necessary): _____

Does the child or youth take medications as prescribed? Yes No

SUICIDE/HOMICIDE RISK: Yes No Unknown

Please describe recent suicidal ideation, suicide attempts or homicidal ideation: _____

Please describe past history of suicidal ideation, suicide attempts or homicidal ideation: _____

PSYCHIATRIC HOSPITALIZATION: Unmet Needs Needs Met Unknown

Currently inpatient? Yes No Admit date: _____ Anticipated D/C date: _____

Please list any previous psychiatric hospitalizations: _____

MENTAL HEALTH TREATMENT: Unmet Needs Needs Met Unknown

Please list any previous outpatient treatment, including current: _____

Brief history of illness: _____

Does the child or youth have a history of violence to self or others? Yes No If yes, please explain.

Behavioral Symptoms (check all that apply): Depression Anxiety
 Phobias Suicidal ideation or attempt Property destruction
 Aggression Cruelty to animals Fire-setting
 Sleep problems Bed-wetting or soiling Physical complaints
 Developmental delays Inappropriate sexual behavior Other: _____

HEALTH CARE: Unmet Needs Needs Met Unknown
Primary Care Provider: _____ Phone: _____
Medical Conditions: _____
Allergies: _____

SUBSTANCE ABUSE: Unmet Needs Needs Met Unknown
Please list past and present use and treatment: _____

Treatment Provider: _____ Clinician: _____ Phone: _____

LEGAL INVOLVEMENT: Unmet Needs Needs Met Unknown
History of violence, PINS involvement, Juvenile Delinquent status, Court involvement, and probation: _____

Contact (probation officer, PINS worker, etc.): _____ Phone: _____

FINANCIAL MANAGEMENT: Unmet Needs Needs Met Unknown
Check if applicable: SSI Application pending for: Medicaid SSI
Medicaid #: _____ Medicare #: _____ Other Insurance: _____
Please list any financial management needs, including SSI application and/or family income source: _____

LIVING ARRANGEMENT: Unmet Needs Needs Met Unknown
History of out-of-home placement: Foster Care Group Home RTF Other: _____
Please list current living arrangement: _____

EDUCATIONAL FUNCTIONING: Unmet Needs Needs Met Unknown
 Academic functioning below grade level Special education services (Classification: _____)
 School suspensions and/or expulsions Aggressive towards teachers
 Conflict with peers Unresponsive to teacher direction
 Fails to participate Lacks friends
 Inconsistent attendance Currently on home instruction

Summary of school performance and history: _____

TRANSPORTATION: Unmet Needs Needs Met Unknown

Please list current transportation needs: _____

SOCIAL SUPPORTS/FAMILY FUNCTIONING: Unmet Needs Needs Met Unknown

Supports/social clubs: _____

Leisure time activities: _____

Identified needs: _____

- | | |
|---|---|
| <input type="checkbox"/> Supportive family unable to cope with child's disability | <input type="checkbox"/> Parent(s) unable to control child's behavior |
| <input type="checkbox"/> Family violence | <input type="checkbox"/> Substance abuse by parent(s) |
| <input type="checkbox"/> Parent(s) have criminal record | <input type="checkbox"/> Parent(s) are intellectually limited |
| <input type="checkbox"/> Parent(s) inconsistent with treatment and/or medication | <input type="checkbox"/> Current CPS involvement |
| <input type="checkbox"/> Psychiatrically ill parent(s) | History of hospitalizations: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Psychiatrically ill sibling(s) | History of hospitalizations: <input type="checkbox"/> Yes <input type="checkbox"/> No |

Is child/youth aware of this referral? Yes No Is child/youth interested in services? Yes No

Please list child or youth and family strengths and skills: _____

| SERVICE NEEDS: | Needs Met | Low Priority | High Priority |
|------------------------------|--------------------------|--------------------------|--------------------------|
| Psychiatric Services: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Medication Management: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Substance Abuse Services: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Living Arrangements: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Self-Care: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Legal: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Benefits/Financial: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Transportation: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Work/School: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Social/Family Relationships: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Crisis/Safety Planning: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Please add any additional comments: _____

Required information:

- Consent for release of information
- Psychiatric evaluation (most recent)
- Treatment plan (most recent)
- Admission/discharge summaries (most recent)

Please send form and required information to:

SPOE Coordinator, Office of Community Services
 230 Maple Street
 Glens Falls, NY 12801
 Phone: (518) 792-7143 Fax: (518) 792-7166

APPLICATION FOR CHILD AND YOUTH CASE MANAGEMENT SERVICES

This application is for use in referring children and youth to a variety of mental health support programs funded by the New York State Office of Mental Health and overseen locally by the Office of Community Services for Warren and Washington Counties. Providers include Warren-Washington Association for Mental Health, Behavioral Health Services of Glens Falls Hospital, Parsons Child and Family Center, and St. Catherine's Center for Children.

The primary objective of these programs is to provide support and services to children with serious emotional disturbance and their families in order to improve their ability to function within their homes, schools and communities, thus reducing the need for hospitalization or placement outside the home.

Supportive Case Management and Intensive Case Management Programs provide linkage and referral to services, advocacy, coordination of services between the family and system, crisis intervention, and support and monitoring. *The Home and Community-Based Waiver Services* program is designed to serve children and youth who might otherwise be admitted to institutional levels of care. Services include individualized care coordination, crisis response, intensive in-home services, respite care, family support and skill-building. *Family-Based Treatment* is considered the least restrictive form of out-of-home therapeutic placement for children with severe emotional disorders. Care is delivered in private homes with specially trained foster parents.

A child or youth qualifies for these services if he or she is:

- experiencing a serious emotional disturbance or behavioral disorder;
- at risk of being hospitalized, re-hospitalized, or placed outside the home;
- having difficulty functioning in the home, school or community;
- involved in multiple systems (mental health, special education, family court, etc.); and
- engaged in clinical treatment or services which have not been successful.

Eligibility for admission to these programs is determined by the *Single Point of Entry (SPOE) Committee*. Each provider agency participates in the committee, and their input helps to ensure that each applicant receives the appropriate level of care to meet his or her needs. Availability of services is limited, and there may be a delay in receiving services even after an applicant has been determined eligible. If the referring agent or parent/guardian is not satisfied with the committee's recommendations, they have the right to appeal the decision by contacting this office. However, the SPOE committee and participating programs reserve the right to make the final determination.

The attached application should be filled out completely. In addition, the referring agent should attach copies of:

- **Signed release of information** (*with, if possible, releases of information for other involved providers*);
- **Psychiatric evaluation** (*most recent*);
- **Current treatment plans** (*most recent*); and
- **Relevant admission and discharge summaries** (*most recent*)

The application and any pertinent information should be forwarded to:

SPOE Coordinator
Office of Community Services
230 Maple Street
Glens Falls, NY 12801
Telephone: (518) 792-7143
Fax: (518) 792-7166

After receiving and reviewing the completed application, we will contact you as soon as possible regarding the next step in the process.

Thank you for your interest in our programs.

**SINGLE POINT OF ENTRY COMMITTEE
CONSENT FOR RELEASE OF INFORMATION**

Name: _____ Gender: _____ DOB: _____

The Single Point of Entry Committee (SPOE) is composed of representatives of community agencies including, but not limited to, the Office of Community Services, the Warren-Washington Association for Mental Health, Behavioral Health Services of The Glens Falls Hospital, Parsons Child and Family Center, Northeast Parent and Child Center, Upstate Respite Services, St. Catherine's Center for Children, Capital District Psychiatric Center, the Departments of Social Services for Warren and Washington Counties, the Departments of Probation for Warren and Washington Counties, the New York State Office of Mental Retardation and Developmental Disabilities, and representatives of local school districts. In order to determine the most appropriate level of service based on strengths, needs, and availability of program openings, I give my permission for members of the SPOE Committee to exchange information between the agencies listed above and to obtain information from and/or release information regarding the above named child to the following Person, Organization, Facility, or Program:

Name and Title of Person/Organization/Facility/Program

Address of Person/Organization/Facility/Program

Phone Number of Person/Organization/Facility/Program

The extent or nature of information to be disclosed includes:

- | | |
|--|--|
| <input type="checkbox"/> Clinical summaries (i.e. psychiatric evaluations) | <input type="checkbox"/> Treatment plans and treatment plan reviews |
| <input type="checkbox"/> Admission and/or discharge summaries | <input type="checkbox"/> Notes of psychiatric or other clinic visits |
| <input type="checkbox"/> Medication records and laboratory results | <input type="checkbox"/> Other: _____ |

I understand that the above information is protected by Mental Hygiene Law 33.13 governing confidentiality of clinical records and/or by Federal Regulation 42 CFR governing confidentiality of Alcohol and Drug Abuse Records and cannot be disclosed without my written consent unless otherwise provided for in law or regulations. I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that action has been taken in reliance on my consent. Re-disclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part. I understand that this information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. The duration of this authorization is one year, unless I specify a date, event or condition upon which it will expire sooner. The date, even or condition upon which consent will expire sooner than noted above is: _____.

The following is a brief description of what I would find most helpful for my child and family:

| | | | |
|---|---------------|-------------------------------------|---------------|
| _____ Child or Youth (Name) | _____ Date | _____ Child or Youth (Signature) | _____ Date |
| _____ Parent or Guardian (Signature) | _____ Date | _____ Witness (Signature) | _____ Date |