

Catholic Charities Universal Children's Services Referral Form REFERRAL INFORMATION Date of Referral: _____	Child's Name (Last, First, M.I.) _____ Male <input type="checkbox"/> Female <input type="checkbox"/> Date of Birth: _____ Unit: <i>Broome</i>
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Please refer this case to: Boys Community Residence CCSI Children's Flex Team Home & Community Based Waiver
 Harbour Home ICM Mentoring Respite SCM

1. Referral Source Information:	
Person making the referral (name, title): _____ Telephone: () _____ Agency: _____ Telephone: () _____ Primary Referral Organization Affiliation: ___ Mental Health ___ Health ___ Substance Abuse ___ Probation/Parole ___ Social Services ___ Juvenile Justice ___ Special Education ___ Church/Religious/Spiritual ___ Other (specify): _____	

2. Demographic Information:	Enter the Name, gender and date of birth in the information box at the top right.
Child's Current Address: _____ <div style="text-align: right; font-size: small;">(City) (State) (Zip Code)</div> Primary Language of Communication: _____ Race/Ethnicity: _____ ___ 1. English ___ 1. White, Non-Hispanic ___ 4. Asian/Pacific Islander ___ 2. Spanish ___ 2. Black, Non-Hispanic ___ 5. Chinese ___ 3. American, Sign Language ___ 3. American Indian ___ 6. Filipino ___ 88. Other, specify: _____ ___ 7. Hispanic ___ 89. unknown	

3. Living Environment/Support System:	The child must be capable of being cared for in the community if provided access to services. Describe the current residence, living environment, custodial relationships, and informal support systems that support the family's ability/desire to participate and support the child at home and in the community.
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Parent/Guardian Name: _____ Home phone: () _____ Address: _____ Work phone: () _____ Address: _____ Cell phone: () _____	
Relationship to Child/Custody Status: ___ 1. Biological Parents ___ 2. Adoptive ___ 3. Other Family or Legal Guardian ___ 4. Local DSS ___ 5. Emancipated Minor	

Emergency Contact Name: _____	Emergency Contact Phone: _____
Current living Situation: ___ 1. Independent Living ___ 9. DSS Facility Foster Care ___ 17. Shelter for Homeless ___ 2. Two-Parent Family ___ 10. OMH C & Y Community Residence ___ 18. Residential School (SED) ___ 3. One-Parent Family ___ 11. Teaching Family Home ___ 19. Residential Treatment Center (DSS) ___ 4. Two-Parent Adoptive Family ___ 12. DSS Group Home ___ 20. Residential Treatment Facility (OMH) ___ 5. One-Parent Adoptive Family ___ 13. OCFS Group Home ___ 21. Psychiatric Inpatient Care ___ 6. Parent w/ mental health issues ___ 14. Family Based Treatment Program ___ 22. OCFS Facility ___ 7. Parent w/ substance abuse issues ___ 15. DSS Specialized Foster Care ___ 23. Jail ___ 8. Relative's home ___ 16. Crisis Shelter Care ___ 24. Homeless/Streets/Abandoned building ___ 99. Unknown ___ 25. Other: (specify) _____	

IS THE CHILD AT IMMINENT RISK OF PLACEMENT ___ YES ___ NO
 IF YES, THROUGH WHAT SYSTEM _____ WHAT TYPE OF PLACEMENT _____

B. If child is living in any setting numbered 8 through 21 listed in A, when is he/she anticipated to be discharged from that setting? Date – month: _____ year: _____

(a) . Names and ages of siblings (if any)	Diagnosis (if any)

Child's Name (Last, First, M.I.)	
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4. Financial and Insurance Information	
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A. Type of health coverage (for this child):
 ___ 1. Private, third party coverage payor
 ___ 2. CHP
 ___ 3. FHP
 ___ 4. Medicaid # _____
 ___ 5. VA/Military
 ___ 6. Other
 ___ 7. None

B. Medicaid Status: ___ Eligible ___ Application Pending ___ Not Applied

C. Is the child a citizen of the United States? ___ yes ___ no
If no, is the Child a legal resident of the United States? ___ yes ___ no

D. Does the Child have any income of their own? ___ yes ___ no
(include SSA, Child Support) If yes, list sources and amounts.

E. Does the Child have any resources of his/her own? ___ yes ___ no
if yes, list resources and value:

F. Income level of family: ___ under \$18,000 ___ \$18,000-\$30,000 ___ \$30,000 ↑

G. Does the family get ___ Food Stamps ___ HEAP ___ SSI ___ Public Assistance

Social Security # _____ - _____ - _____

A. Indicate the degree to which this child exhibits the following symptoms or behaviors which are attributable to an emotional disorder within the past year:

	History	Not Present	Mild <small>(occasional incidents)</small>	Moderate <small>(Interferes w/ daily functioning)</small>	Severe Impairment
1. Depressed mood	_____	_____	_____	_____	_____
2. Anxiety/Nervousness	_____	_____	_____	_____	_____
3. Suicidal symptoms (attempts, threats or indications)	_____	_____	_____	_____	_____
4. Mood swings	_____	_____	_____	_____	_____
5. Anger/Temper tantrums	_____	_____	_____	_____	_____
6. Hyperactivity (problems with attention, destructible, impulsive)	_____	_____	_____	_____	_____
7. Aggressive behavior (physical, sexual etc.)	_____	_____	_____	_____	_____
8. Irritability	_____	_____	_____	_____	_____
9. Psychotic symptoms (hallucinations, delusions, bizarre behaviors)	_____	_____	_____	_____	_____
10. Obsessive/compulsive behavior	_____	_____	_____	_____	_____
11. Sleep problems	_____	_____	_____	_____	_____
12. Elimination problems (bowel, bladder)	_____	_____	_____	_____	_____
13. Eating Problems	_____	_____	_____	_____	_____
14. Phobias and fears	_____	_____	_____	_____	_____
15. Cruelty to animals	_____	_____	_____	_____	_____
16. Fire setting	_____	_____	_____	_____	_____
17. Inappropriate sexual behavior/acting out	_____	_____	_____	_____	_____
18. Antisocial/delinquent behavior	_____	_____	_____	_____	_____
19. Alcohol Abuse	_____	_____	_____	_____	_____
20. Substance Abuse	_____	_____	_____	_____	_____
TOTAL	_____	_____	_____	_____	_____

How long have the mental health problems(s) existed: ___ one year ___ less than one year ___ unknown

B. Indicate the nature and degree of other disabilities:

	Not Present	Mild	Moderate	Severe
1. Developmental Delays	_____	_____	_____	_____
2. Learning disability	_____	_____	_____	_____
3. Physical handicap	_____	_____	_____	_____
a. Blind	_____	_____	_____	_____
b. Visually impaired	_____	_____	_____	_____
c. Deaf	_____	_____	_____	_____
d. Hard of Hearing	_____	_____	_____	_____
e. Speech Impairment	_____	_____	_____	_____
f. Other, specify: _____	_____	_____	_____	_____
4. Mental Retardation	_____	_____	_____	_____
5. Disabling or life-threatening medical condition	_____	_____	_____	_____
TOTAL	_____	_____	_____	_____

C. Diagnosis(es) if documented:
 Axis I _____
 Axis I _____
 Axis II _____
 Axis III _____
 Axis IV _____
 Axis V GAF Level _____ Date Determined _____
 Psychiatrist/Doctor: _____ Counselor/Therapist _____

Child's Name (Last, First, M.I.) _____

D. Indicate the degree to which this child's behavior is currently due to emotional disturbance in each of the following areas:

	Not Affected	Mild Impairment	Moderate Impairment	Severe Impairment
1. Self care (adequate personal hygiene and ability to perform age appropriate chores)	_____	_____	_____	_____

2. Social relationships (ability to establish or maintain satisfactory relationships w/ peers & adults)				
3. Family life (capacity to live in a family)				
4. School performance/learning ability (satisfactory attendance, able to function in the learning environment & complete assgns.)				
5. Self direction (behavioral controls, decision making judgment & value system)				
TOTAL				

E. Indicate risk factors, which apply to either past or present:

Not Applicable Past History Current Evidence

1. Parent/Child Conflict			
2. Caretaker/child Conflict			
3. Sexually Abused			
4. Physically Abused			
5. Physical or medical neglect			
6. Psychological or Social neglect			
7. Self-destructive behaviors			
8. At-risk of causing personal injuries/significant property damage as a result of emotional disturbance			
9. HIV/AIDS			
10 Runaway Risk			
11 Verbally Aggressive			
12 Med. Non-Compliance			
13 Weapons in the home			
TOTAL			

CHILD/FAMILY STRENGTHS	SERVICE NEEDS	ENVIRONMENTAL STRESSORS
Concern for others <input type="checkbox"/>	Advocacy <input type="checkbox"/>	Bereavement <input type="checkbox"/>
Conflict resolution - nonviolent <input type="checkbox"/>	After school programming <input type="checkbox"/>	Domestic violence <input type="checkbox"/>
Discipline – constructive <input type="checkbox"/>	Anger management <input type="checkbox"/>	Economic stress <input type="checkbox"/>
Extracurricular/Hobbies <input type="checkbox"/>	Case management for Adult <input type="checkbox"/>	Emotional abuse <input type="checkbox"/>
Family support <input type="checkbox"/>	Case management for child <input type="checkbox"/>	Family(caretaker)/Child conflict <input type="checkbox"/>
Follow through <input type="checkbox"/>	Childcare <input type="checkbox"/>	Homelessness/Transience <input type="checkbox"/>
Good communication skills <input type="checkbox"/>	Counseling/Family <input type="checkbox"/>	Legal/Family <input type="checkbox"/>
Good decision-making skills <input type="checkbox"/>	Counseling/Group <input type="checkbox"/>	Marital/Family problems <input type="checkbox"/>
Identifies need for assistance <input type="checkbox"/>	Counseling/Individual <input type="checkbox"/>	Medical problems/Child <input type="checkbox"/>
Loving/Caring <input type="checkbox"/>	Crisis intervention <input type="checkbox"/>	Medical problems/Family <input type="checkbox"/>
Participates in activities w/child <input type="checkbox"/>	Cultural enrichment <input type="checkbox"/>	Mental health/Child <input type="checkbox"/>
Positive adult role model <input type="checkbox"/>	Educational <input type="checkbox"/>	Mental health/Family <input type="checkbox"/>
Positive expectations for child <input type="checkbox"/>	Emergency services <input type="checkbox"/>	Multiple family separations <input type="checkbox"/>
Positive peer group <input type="checkbox"/>	Family preservation/Intensive in-home <input type="checkbox"/>	Out of home placement <input type="checkbox"/>
Prefers child remains at home <input type="checkbox"/>	Family support group <input type="checkbox"/>	Physical abuse <input type="checkbox"/>
Regular source of income <input type="checkbox"/>	Financial assistance <input type="checkbox"/>	Sexual abuse <input type="checkbox"/>
Residential stability <input type="checkbox"/>	Homemaker/Housekeeping <input type="checkbox"/>	Severe neglect <input type="checkbox"/>
Safe environment <input type="checkbox"/>	Housing <input type="checkbox"/>	Substance abuse/Family <input type="checkbox"/>
Social outlets <input type="checkbox"/>	Independent living program <input type="checkbox"/>	Teen pregnancy/Parenting <input type="checkbox"/>
Spends time at home <input type="checkbox"/>	Legal <input type="checkbox"/>	Witness/victim to serious crime <input type="checkbox"/>
Spirituality <input type="checkbox"/>	Life skills training <input type="checkbox"/>	Sibling conflict <input type="checkbox"/>
Supervision – appropriate <input type="checkbox"/>	Medical care <input type="checkbox"/>	Parent/Caretaker with Mental Health Issues <input type="checkbox"/>
Works well with provider <input type="checkbox"/>	Medication monitoring <input type="checkbox"/>	Describe:
Others:	Mentoring <input type="checkbox"/>	
	Neurological services <input type="checkbox"/>	
	Other <input type="checkbox"/>	
	Parenting skills/Education <input type="checkbox"/>	Parent/Caretaker w/ Substance Abuse Issues <input type="checkbox"/>
	Pregnant/Mothering program <input type="checkbox"/>	Describe:
	Psychiatric hospital <input type="checkbox"/>	
	Recreational <input type="checkbox"/>	
	Respite <input type="checkbox"/>	
	Socialization <input type="checkbox"/>	Others:
	Substance abuse treatment <input type="checkbox"/>	
	Summer camp <input type="checkbox"/>	
	Transportation <input type="checkbox"/>	
	Vocational <input type="checkbox"/>	

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6. Mental Health Treatment History:

History of Mental Illness:

- ___ Currently resides in an institutional placement and has resided in such a hospital for at least 180 consecutive days, or
- ___ Had resided in an institutional placement within the past 6 months and was hospitalized for at least 30 consecutive days, or
- ___ Is eligible for institutional placement, including a hospital which provided intermediate or long-term care and treatment, or
- ___ Has applied for institutional placement, including a hospital which provides intermediate or long-term care and treatment

Hospital Name:	Date of Service:	Treatment:

Outpatient Mental Health Services:	Date:	Treatment:

Emergency Services used:	Date of Service:	Reason:
CPEP		
Emergency Respite:		

7. Medical/Health Concerns: _____ **Allergies:** _____

Medications: _____
Medications: _____
Medications: _____

8. Educational Information: _____ Indicate educational needs: summarize nature/degree or attach documentation

A. CSE Classification:	B. Present Educational Placement:	C. Educational Problems:
NO Conditions <input type="checkbox"/>	1. Regular class in age-appropriate grade <input type="checkbox"/>	1. Academic Problems <input type="checkbox"/>
1. Emotionally Disturbed <input type="checkbox"/>	2. Regular class, behind at least one grade <input type="checkbox"/>	2. Truancy <input type="checkbox"/>
2. Learning Disabled <input type="checkbox"/>	3. Special class for students with handicapping conditions <input type="checkbox"/>	3. School Behavior Problems <input type="checkbox"/>
3. Sensory Impaired <input type="checkbox"/>	4. Residential school for educationally (emotionally) handicapped <input type="checkbox"/>	4. Gang Involvement <input type="checkbox"/>
4. Physically Disabled <input type="checkbox"/>	5. Vocational training only <input type="checkbox"/>	5. Suspension <input type="checkbox"/>
5. Other Health Impaired <input type="checkbox"/>	6. Part-time vocational/educational <input type="checkbox"/>	Other <input type="checkbox"/>
6. Multiply Handicapped <input type="checkbox"/>	7. Not enrolled in school <input type="checkbox"/>	<input type="checkbox"/>
88. Not classified <input type="checkbox"/>	8. High School graduate/GED <input type="checkbox"/>	<input type="checkbox"/>
99. Unknown <input type="checkbox"/>	9. Day Treatment <input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	10 Home instruction <input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	11 BOCES <input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	12 Other (specify) <input type="checkbox"/>	<input type="checkbox"/>

D. School District: _____ **Grade:** _____ **School contact:** _____ **Phone:** _____

9. Interagency Involvement: _____ Indicate all known agencies involved with this child in the present.

- ___ 1. Mental Health (*specify*) a. Inpatient b. RTF/FBT/CR c. Day Treatment d. Outpatient e. ICM f. unknown
- ___ 2. Juvenile Justice a. PINS Div. b. PINS Prob. c. JD Div. d. JD Prob. e. at risk of: _____
- ___ 3. Family Court
- ___ 4. DSS a. Foster Care b. Prevention c. Child Protection d. Central Intake e. unknown
- ___ 5. Unknown

Child's Name (Last, First, M.I.)	
Contact Person	Phone #

10.	Family's Perception/Needs:	Describe the family's perception service needs, how those needs are being met, & any barriers to meeting those needs. Include the child's (& family members') strengths & informal support systems that assist in meeting the service needs identified.

Needs/Goals:

Barriers:

If applying for Residential Placement in the Boys Community Residence or the Harbour Program, you must also, include the following:

1. Psychiatric Assessment
2. Psychological Evaluation
3. Psychosocial Assessment including family History
4. Educational/Vocational Assessment – including (if applicable) IEP
5. Medical Examination

All the above information must be dated within 90 days preceding the date of referral. Additional information will be requested prior to placement.

11.	Signature:	Include printed name, signature, title & date	
Signature/Title		Date	
Parent Signature		Date	

Child's Name: _____

FOR OFFICE USE ONLY

Date Referral Received: _____ Date of SPOA Meeting: _____

Date Parent Advocate Assigned: _____
Parent Advocate Contact Dates: _____

Time Presenting: _____
Parent Attending: _____

Currently Hospitalized: Yes / No
Where: _____

Currently in Placement: Yes / No
Where: _____

Anticipated Date of Discharge: _____

Anticipated Date of Discharge: _____

SERVICES BEING REQUESTED: _____

SPOA COMMITTEE OUTCOME

Recommended for: _____

Waiting List **Date Assigned** **Date Opened**

Yes / No

Yes / No

Yes / No

Yes / No

If on Waiting List – Interim Plan:

Deemed inappropriate for:
Program

Reason

Alternative Suggestions:

SPOA COORDINATER

PARENT ADVOCATE