

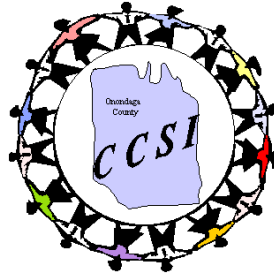
We're About

*We're about love and respect.
Truly caring for our families.
We're about dreams and reality,
hopes for the future, never giving up.*

*We're about love and respect.
Wisdom and truth,
Caring and sharing,
Heartache and pain,
Sunshine and roses and
doing it over again.*

*We're about love and respect.
Never a dull moment
always on the run
God, aren't we having fun?!
Up and down and backwards and forwards
but never staying down.
A kind word, a gentle hand.*

*We're about love and respect.
Pull out the strengths,
pull out the love.
Get people thinking on how they rise above.
Making sure all the "i's" are dotted
and "t's" are crossed.
Never being alone.
We're about love and respect.*



SECTION F

STEP 2 TRAINING

CCSI TEAM POLICY AND PROCEDURES

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CCSI Team Policies & Procedures

Please refer to Step 1 – SECTION D for OCMS office procedures. CCSI Team Procedures are in addition to those in force by OCMS.

It is expected that work performed as a Parent Partner will be done from the office, not from your home. If, on occasion, it is necessary to make client phone calls or meet with a parent in an emergency, advise the Parent Partner Coordinator promptly to obtain approval to bill those hours.

CCSI staff and Parent Partners do not receive paid lunch periods. Please do not include lunch times in hours worked; however, a ½ hour lunch period per 5 hour shift worked is expected.

At present, all Parent Partner positions are part time. Regular work schedules will be determined by the Parent Partner and Parent Partner Coordinator. These will vary from person to person. If you are unable to report to work on a scheduled day or time, it is necessary that you advise the Parent Partner Coordinator **AND** the Human Resource Administrator at OCMS.

To follow is a sample **Time Sheet** and Time Off Request form. It is imperative that time sheets be completed and submitted to the Parent Partner Coordinator by noon on the Friday they are due to be submitted. The Parent Partner Coordinator must review, approve and have them submitted to Human Resources by the close of business on that day.

Time Off Request forms must be completed and submitted to the Parent Partner Coordinator as soon as:

- a) You know you will be taking the time off, or
- b) You report back to work after an illness or unexpected absence.

After the Parent Partner Coordinator has approved the time off, the form will be submitted to Human Resources and attached to your time sheet for the appropriate pay period.

Attendance at CCSI Staff Meetings is *mandatory*.

Office supplies are purchased with the Program Coordinator's approval by the Program Assistant.

Incoming mail is distributed to your mail folder, which are located in the Program Assistant's office.

See CCSI's Program Assistant for:

- Copier use instruction/questions
- Fax machine instruction/questions
- Telephone use instruction/questions

CCSI Team Policies & Procedures

Conference and Workshop Attendance

Conference Request forms (copy attached) need to be completed and submitted to CCSI supervision for attendance approval. These must be submitted at least 2 weeks prior to the event.

If you wish to attend a particular conference and/or workshop, and are **requesting CCSI sponsorship** (ie: use of work hours) for the event, the following protocol applies:

An allotment of 20 paid hours per year are available to use for conference/workshop attendance.

Forms are available from the Program Assistant. Submit your completed form to your immediate supervisor for approval. If approved, it will be given to the CCSI Coordinator for his/her approval, and finally to the program assistant for processing.

Participation will be approved by the director based on funding availability to cover costs, and on how the conference pertains to your work.

You will be asked to give a 15 minute presentation of highlights of attended conferences at a staff meeting following the event. In that way, we all learn!

Copies of **all** conference/workshop requests (approved or disapproved) are kept on file in the Program Assistant's office.

Please know that we support your efforts to attend as many of these as is possible!

This form must be submitted at
least 2 weeks prior to event

Date submitted: _____
Supervisor approval: _____

ATTACH COPY OF CONFERENCE FLYER TO THIS FORM!

CONFERENCE ATTENDANCE REQUEST FORM:

CCSI Participant's Name: _____

Guest (if any) _____

Name of Conference: _____ Date of Conference: _____

Location of Conference: _____ Conference Duration: _____

Registration Cost: _____

(FOR CONFERENCES OF 2 OR MORE DAYS)

Travel Arrangements Needed: Yes No

Travel Costs: _____

Travel Dates: Depart _____ Return _____

Copies of all travel

How will attending this conference impact on your CCSI work with families & children:
(Be specific)

I will plan to give a 15 minute summary of key points from this conference at Staffing Meeting on: _____

Conference Attendance approved:

Conference Attendance denied

Program Director Date

Program Director Date

Budgetary _____ Not applicable _____

CCSI Team Policies & Procedures

Community Wrap-Around Funds

Community Wrap-Around Funds are intended to be flexible and responsive to the current needs of children and families in Onondaga County. Wrap-around funds are derived from Family Support Funding from the NYS OMH.

Eligibility:

- Children with an emotional disability from Onondaga County.
- Documented need for Wrap-Around funds to support an integrated service plan.

There are two primary mechanisms by which flex funds may be used:

- **Mental Health Service Expansion, and Client Specific Services**
 - **Mental Health Service Expansion:** Community Wrap-Around funds may be used to create expanded, cost-effective services that groups of children can utilize. Service expansion proposals must meet the eligibility criteria and model the principles of the CCSI program. Proposals should clearly articulate how:
 - Broad access to the service is assured.
 - Parents are partners in the planning, development and delivery of services.
 - Residential Placements are minimized.
 - Individual support to families is maximized

Proposals will be awarded funds on an annual basis, beginning January 1. Proposals are to be submitted to the OCDMH and will be recommended to Tier II of CCSI by the Deputy Commissioner of Mental Health.

- **Client Specific Services:** Community Wrap-Around funds may be used to implement creative, cost effective service plans for individual children and families. Client specific requests must meet the eligibility criteria and model the principles of the CCSI program. Client Specific requests may include food, lodging, clothing, crisis specialist/respite, transportation, housing assistance, educational supports and leisure time activities associated with the client's service plan. All entitlements must be exhausted prior to requesting Community Wrap-Around funds.

Requests must be completed on a Community Wrap-Around fund request form (SEE ATTACHED EXAMPLE). Completed forms should be given to your direct supervisor and the CCSI Program Director. Please attach a memo to the form outlining your specific request.

The CCSI Director has approval authority for expenditures that are:

- a) under \$100, and
- b) consistent with the guidelines outlined above.

Requests for services over \$100 must be pre-approved by the Deputy Commissioner of Mental Health. Tier II of CCSI will review and approve a quarterly report depicting the Client Specific Service expenditures.

COMMUNITY WRAP-AROUND

The following chart shows categories for Client Specific Service expenditures:

<u>CATEGORY</u>	INCLUDES
Food/Meals	Costs of meals, groceries and other necessary food items. Including household and hygiene items. <i>Not to be used for any alcohol or tobacco products.</i>
Lodging/Respite/Hotel	Purchase of shelter.
Utilities	Emergency payment of heating, electric and telephone.
Crisis Specialists	Hourly specialists to support families through crisis period.
Transportation	Consistent with implementation of service plan.
Furnishings	Basic home supplies.
Educational Supports	Tutoring or other supports.
Leisure Time	Beneficial leisure time activities and recreational equipment.
Miscellaneous: Household Repairs – Medication	One-time expenditures that are not available from other sources or entitlements.



CCSI Statistics

- CCSI Stat sheets **MUST** accompany hours sheets when submitted monthly.
- Hours will not be approved for payment until stat sheets are in.

To complete your stat sheets, follow these guidelines and those shown on the following examples. If you have questions, please review with your coordinator.

CCSI STATISTICS FORM

PAGE 1

Parent Partner:		<i>(fill in your name)</i>
Month/Year:		<i>(fill in current month and year)</i>
Number of Families Served:		<i>(total count of children on this form)</i>
<u>Column #</u>	<u>Column Title</u>	<u>Information Needed</u>
(left to right on form)		
Col. 1	Child's Name	<i>fill in first & last name of child</i>
Col. 2	Date of Referral	<i>fill in date you received referral</i>
Col. 3	Date of Contact	<i>fill in date you first make contact with family</i>
Col. 4	New	<i>check this column if "Date of Contact" column contains date in current month. (Do not check if child is carried over from a previous month.)</i>
Col. 5	Re-referral	<i>put date of previous discharge from CCSI if client is a re-referral. (Only complete this box once, in the month when family is a new re-referral.)</i>
Col. 6	Refused Services	<i>date when family refuses CCSI services (see pg. 2)</i>
Col. 7	# Family Sessions w/o Tier 1	<i>enter (using numbers, not hash marks) the number of times you meet informally with the family. List formal meetings in the Comments column.</i>
Col. 8	Tier 1 Meeting Date	<i>list only Tier 1 meetings held in the current month</i>
Col. 9	Phone Contact/Family	<i>enter the number of times you contacted the family, not service providers (use numbers).</i>
Col. 10	Phone Contact/Svc. Pro.	<i>enter the number of time you contacted service providers regarding this child/family.(use numbers)</i>
Col. 11	Unreachable	<i>date unreachable letter sent. (To be sent after 3 failed attempts to contact family.)</i>
Col. 12	Date of Discharge	<i>date Discharge letter sent.</i>
Col. 13	Comments	<i>Use this area for notes to the director about a family or your activities that are NOT covered in any other area. If you need additional space, write on the back of page 1 of stat form.</i>

CCSI STATISTICS FORM

PAGE 2

2.	Reason services were refused	<i>Fill in the child's name and be specific about the reasons the family gave you for refusing CCSI's services. (see example)</i>
3.	Referrals out of program	<i>On total line, fill in number by counting referrals to service providers from Tier 1 family plans done in current month.</i>
		<i>In "TO-FOR" section, list the child's name, the service provider referred to and the service they were referred for.</i>
4.	Systems activities – from Tier	<i>List child's name and systems collaboration that took place as a result of a Tier 1, held in current month, that you feel would not have happened without the Tier 1 meeting.</i>
5.	Systems activities- NO TIER	<i>List child's name and your activities(or those of a service provider at your request) for a child without a Tier 1 meeting being held.</i>

2. Reasons services were refused (be specific) (eg: Parents refused services, child hospitalized, child in RTF, etc.)

Child's name – specific reason

3. Activities: Number of Referrals Out of Program as a result of Tier I process _____
State SERVICE PROVIDER referral was made to, and what SERVICE it was for.- (eg: HBCI / Respite)

Child's Name:

TO SERVICE PROVIDER:

FOR SERVICE:

4. - Systems Activities – What linkages were made between systems at Tier 1 meetings? (What happened at Tier 1 meeting that otherwise would **not** have happened for a family and/or child? eg: School district revised transportation procedures in order to provide transportation to an after school program)

Child's name - Activity

5. - Systems Activities NOT resulting in Tier I

Child's name - Activities of Parent Partner &/or Service Provider for child without a Tier 1

2. Reasons services were refused (be specific) (eg: Parents refused services, child hospitalized, child in RTF, etc.)

Child's name – specific reason

3. Activities: Number of Referrals Out of Program as a result of Tier I process _____
State SERVICE PROVIDER referral was made to, and what SERVICE it was for.- (eg: HBCI / Respite)

Child's Name:

TO SERVICE PROVIDER:

FOR SERVICE:

4. - Systems Activities – What linkages were made between systems at Tier 1 meetings? (What happened at Tier 1 meeting that otherwise would **not** have happened for a family and/or child? eg: School district revised transportation procedures in order to provide transportation to an after school program)

Child's name - Activity

5. - Systems Activities NOT resulting in Tier I

Child's name - Activities of Parent Partner &/or Service Provider for child without a Tier 1

2. Reasons services were refused (be specific) (eg: Parents refused services, child hospitalized, child in RTF, etc.)

3. Activities: Number of Referrals Out of Program as a result of Tier I process _____
State SERVICE PROVIDER referral was made to, and what SERVICE it was for.- (eg: HBCI / Respite)

Child's Name:

TO SERVICE PROVIDER:

FOR SERVICE:

Heather Lane

HBCI
SSI

Respite
Supplemental Income

4. - Systems Activities – What linkages were made between systems at Tier 1 meetings? (What happened at Tier 1 meeting that otherwise would **not** have happened for a family and/or child? eg: School district revised transportation procedures in order to provide transportation to an after school program)

Heather Lane

Received SSI

5. - Systems Activities NOT resulting in Tier I

2. Reasons services were refused (be specific) (eg: Parents refused services, child hospitalized, child in RTF, etc.)

John Doe – Services refused as child is in RTF

3. Activities: Number of Referrals Out of Program as a result of Tier I process _____
State SERVICE PROVIDER referral was made to, and what SERVICE it was for.- (eg: HBCI / Respite)

<u>Child's Name:</u>	<u>TO SERVICE PROVIDER:</u>	<u>FOR SERVICE:</u>
Heather Lane	HBCI SSI	Respite Supplemental Income

4. - Systems Activities – What linkages were made between systems at Tier 1 meetings? (What happened at Tier 1 meeting that otherwise would **not** have happened for a family and/or child? eg: School district revised transportation procedures in order to provide transportation to an after school program)

Heather Lane Received SSI

5. - Systems Activities NOT resulting in Tier I

Standard Referral Procedure

To follow is a copy of the “Universal Referral Form” . This same form is used for all Children’s Mental Health Services in Onondaga County. At CCSI, Kathryn or the Program Coordinator does the referral intake. They will complete the universal referral form and pass it on to the Parent Partner Coordinator, who will assign a Parent Partner to the family.

Following the Universal Referral Form is the Strength Based Assessment form that CCSI Parent Partners will complete with the family.

The referral process is as follows:

➔ If agency or service provider calls CCSI with a referral, the intake person will:

- 1: Ask if family knows they’re calling
- 2: Ask if the family understands our process

If yes to one or both:

- Review checklist with caller to get an idea as to whether this is an appropriate referral for CCSI.
- Tell the caller to have the family call us
or
- Get the phone number and call the family

If no to one or both:

- Review the CCSI process and send colleague the “dear colleague” packet, ask if they want a brochure sent to the family.
- If brochure is sent to the family, use cover letter advising them to call.



If family calls in with referral:

- 1: Confirm the CCSI process
- 2: Determine if referral is appropriate for CCSI
(* / ^ See Criteria outline which follows)

*** If referral is appropriate:**

- Complete universal referral form
- Give complete blue packet to Parent Partner Coordinator for assignment to a Parent Partner.

^ If referral is inappropriate:

- Explain why to the family and refer them to an appropriate agency.

*** APPROPRIATE REFERRAL CRITERIA:**

Child has a mental health component

and

- Child has been labeled “ED” at school
- Multi-Systems (meaning 1 other system involved plus MH)
- Child is returning to community from RTF

^ INAPPROPRIATE REFERRAL HAS THE FOLLOWING ELEMENTS:

- Child has been kicked out of school and needing an educational advocate is the *only* need.
- Safety concerns or family in crisis (see Crisis Referral)
(**if immediate**, advise to call police, or offer to call for them)
- Single systems involvement
- (eg: child not labeled ED (LD only) and there is no MH component
- Facility calls for discharge planning help.

REFERRAL PROCEDURE

Family In Crisis

When a family contacts CCSI and are in crisis:

- 1: It is important to patiently explain to the family about how CCSI works, and that in order to have a successful tier meeting, that process must be followed.
 - 2: Call the parent daily (if necessary) to make them aware of what work is being done on their case. This “hand holding” can continue right up to the Tier 1 meeting.
 - 3: Empower the parent to know that they will have support through their crisis.
 - 4: Refer them to Parent Support Group.
 - 5: Make sure the family has your business card and business phone number to call when they are in need. Whether to give them your home phone number or not is totally up to you.
-

When a family is in *extreme* crisis:

We define “extreme crisis” as: **The family is dealing with a child who has, or will, harm themselves or others.**

CCSI is not equipped to deal with this type of crisis intervention. The family should be advised to:

- Call CPEP – **448-6555**

Children's Mental Health Continuum of Care REFERRAL FORM

Child's Name: _____ Child's DOB: ____/____/____ Gender: Male
 Female

Parent/Guardian Name: _____

Child's Social Security #: _____ Parent/Guardian Social Security #: _____

Address: _____ Apartment #: _____

Town: _____ Zip: _____ Insurance #/Medicaid CIN# _____

Home Phone: _____ Insurance Co. or Managed Care Provider: _____

Work Phone: _____ Check Here If Not Currently Enrolled in Medicaid:

Yes No

Does child/adolescent meet eligibility criteria for Serious Emotional Disturbance

(See attachment – page 2)

Please state hours of availability to meet: _____

Please check service category(ies) for which child is being referred (ie. Case Management, Placement, Transitional Services.) Complete p. 1-12 for all referrals. Complete the entire package for out of home placements.

COMMUNITY SERVICES

<input type="checkbox"/>	Onondaga Case Management Children's ICM
<input type="checkbox"/>	Hillside Waiver
<input type="checkbox"/>	OCDMH Family Support
<input type="checkbox"/>	CCSI
<input type="checkbox"/>	Other _____

OUT OF HOME PLACEMENT

<input type="checkbox"/>	RTF
<input type="checkbox"/>	Other _____

I consent to release information to the Continuum of Care Work Group and Subcommittee to review this application for the programs listed above. I have reviewed the entire referral form and consent to the release of this information.

Parent/Guardian Signature: _____	Date: ____/____/____
Child's Signature (If Appropriate) _____	Date: ____/____/____
Witness _____	Date: ____/____/____

SED CHECKLIST: TO DOCUMENT YOUNGSTER WITH SERIOUS EMOTIONAL DISTURBANCE

MINIMUM REQUIREMENTS FOR SED: Criterion A must be met, **and** both parts of B **or** C must be met.

Check All That Apply:

_____ Youngster meets age requirement (under 18 years of age).

_____ A. Diagnosis of Designated Emotional Disturbance

Youngster has DSM IV psychiatric diagnosis **other than:**

- alcohol or drug disorders (291.x, 292.xx, 303.xx, 304.xx, 305.xx).
- organic brain syndromes (290.xx, 293.xx, 294. x).
- developmental disabilities (299.xx, 315.xx -319x).
- social conditions (V codes)
- ICD-9-CM diagnoses not having a DSM IV equivalent

B. Extended Impairment in Functioning Due to Emotional Disturbance. (Both parts of B must be met).

_____ Over the last 12 months, continuously or intermittently, youngster has experienced functional limitations **due to emotional disturbance**. Problems must be moderate in at least two areas, or severe in at least one area.

- _____ a. **Self Care** - personal hygiene; obtaining and eating food; dressing; avoiding injuries.
- _____ b. **Family Life** - capacity to live in a family or family-like environment; relationships with Parents
- _____ c. **Social Relationships** - establishing and maintaining friendships; interpersonal interactions with peers, neighbors, and other adults; social skills; compliance with social norms; play and appropriate use of leisure time.
- _____ d. **Self-Direction/Self-Control** - ability to sustain focused attention for long periods of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability.
- _____ e. **Learning Ability** - school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school.

_____ During the last 12 months, continuously or intermittently, youngster has rated 50 or less on the Children’s Global Assessment Scale (CGAS) or the Global Assessment of Functioning (GAF) **because of emotional disturbance**.

C. Current Impairment in Functioning with Severe Symptoms. (Both parts of C must be met).

_____ Youngster **currently** rates 50 or less on the CGAS (or GAF) **because of emotional disturbance**.

_____ Within the past 30 days, youngster has experienced at least one of the following:

- _____ a. Serious suicidal symptoms or other life-threatening, self-destructive behaviors.
- _____ b. Significant psychotic symptoms (hallucinations, delusions, bizarre behavior).
- _____ c. Behavior caused by emotional disturbances that placed the youngster at risk of causing personal injuries or significant property damage.

SECTION II: AT RISK CHECKLIST

A. TO DOCUMENT YOUNGSTER AT RISK OF SERIOUS EMOTIONAL DISTURBANCE

Check all that apply:

- Youngster meets age requirements (under 18 years of age).
- Failed adoption(s).
- Parent with serious/persistent mental illness.
- Parent with history of chronic alcohol and/or drug abuse.

Youngster has experienced **at least one** of the following:

- Has been a victim of physical, emotional or sexual abuse, or severe neglect.
- Has been a victim of, or witness to, serious violent crime or domestic violence.

Has experienced residential disruption caused by:

- Out-of-home placement due to emotional disturbance.
- Multiple family separations.
- Extended period of homelessness.

B. CHILD IS AT RISK OF RESIDENTIAL PLACEMENT IF **ANY ONE** OF THESE CONDITIONS IS MET

- There is a current psychiatric/psychological evaluation recommending placement.
- CSE has approved/is considering residential placement.
- There is a pending application for RTF before the PACC.
- Request for placement has been received by the DSS residential placement unit.
- Child is awaiting placement through the juvenile justice system.
- Child has experienced a previous residential placement.

SECTION III: REFERRAL SOURCE IDENTIFICATION

1. Date of Referral ___ ___ / ___ ___ / ___ ___

2. **Primary** Referral Organization Affiliation:

_____ Mental Health	_____ Juvenile Justice	_____ Caregiver
_____ Social Services	_____ Probation/Parole	_____ Other (please describe below)
_____ Education	_____ Court	_____
_____ Physical Health	_____ Substance Abuse	_____

3. Organization/Program Name: _____

4. Name of Person Making Referral _____ Phone # _____
 Address _____ Town _____ Zip _____
 Fax # _____ E-Mail _____ @ _____

5. **Other** Referral Organization Affiliation (Please check all that apply):

_____ Mental Health	_____ Juvenile Justice	_____ Caregiver
_____ Social Services	_____ Probation/Parole	_____ Other (please describe below)
_____ Education	_____ Court	_____
_____ Physical Health	_____ Substance Abuse	_____

SECTION IV: CHILD AND FAMILY INFORMATION

6. List **all** household members

Name (first and last)	Age	Relationship to Child	School/Employment

7. A. Please indicate the family's strengths that may be utilized to assist the child with services

B. Child's Strengths/Interests/Hobbies/Activities

Child's Name: _____

8. Primary Language

- _____ 1. English
_____ 2. Spanish
_____ 3. American Sign Language
_____ 4. Other, Please Specify _____

9. Race / Ethnic Identity

- _____ 1. White
_____ 2. Black/African American
_____ 3. Asian/Pacific Islander
_____ 4. American Indian
_____ 5. Significant cultural identity (Specify): _____
- _____ 6. Hispanic / Latino
_____ A. Mexican, Mex-Am., Chicano
_____ B. Puerto Rican
_____ C. Cuban
_____ D. Dominican
_____ E. Central American
_____ F. Other (specify): _____

10. Custody Status

- _____ 1. Two parents OR one parent and one stepparent
_____ 2. Mother only
_____ 3. Father only
_____ 4. Foster parent(s)
_____ 5. Sibling(s)
_____ 6. Aunt and/or uncle
_____ 7. Grandparent(s)
_____ 8. Friend (adult friend)
_____ 9. DSS
_____ 10. Other: _____

11. Current Living Situation

- _____ 1. Independent Living
_____ 2. Two-Parent Family
_____ 3. One-Parent Family
_____ 4. Relative's Home
_____ 5. DSS Foster Care
_____ 6. DSS Therapeutic Foster Care
_____ 7. DSS Group Home
_____ 8. OMH C & Y Community Residence
_____ 9. Family Based Treatment Program
_____ 10. Psychiatric Inpatient Care
- _____ 11. Shelter for Homeless
_____ 12. Temporary Housing for Homeless
_____ 13. Residential School (SED)
_____ 14. Residential Treatment Center (DSS)
_____ 15. Residential Treatment Facility (OMH)
_____ 16. OCFS Facility
_____ 17. Jail
_____ 18. Homeless/Streets
_____ 19. Other, Please Specify _____

Child's Name: _____

SECTION V: CHILD'S MENTAL HEALTH CRITERIA

12. A. DSM-IV Diagnosis, If Known

Description

AXIS I _____ **AXIS III** _____

AXIS I _____

AXIS I _____ **AXIS IV** _____

AXIS I _____

AXIS II _____ **AXIS V** Current ____ highest last yr.

AXIS II _____

Date of Diagnostic Evaluation _____

B. IQ Score

Verbal _____ Performance _____ Full Scale _____ Test Date _____

13. Please check below the degree to which this child exhibits the following *current* symptoms or behaviors which are attributable to an emotional disorder or issues leading to referral:

		Not-Present	Mild	Moderate	Severe	Duration of Symptoms <1 year > 1 year
1.	Depressed Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
2.	Anxiety/Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3.	Suicidal threats, ideation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
4.	Suicidal Attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
5.	Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
6.	Anger/Age Inappropriate Tantrums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
7.	Hyperactivity/Impulsivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
8.	Physical Aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
9.	Psychotic Symptoms (Hallucinations, Delusions, Bizarre Behavior)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
10.	Self Abuse/Self Mutilation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
11.	Obsessive/Compulsive Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
12.	Sleep Problems/Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
13.	Encopresis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
14.	Enuresis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
15.	Eating Problems/Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
16.	Phobias and Fears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
17.	Cruelty to Animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
18.	Fire Setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
19.	Inappropriate Sexual Behavior/Acting Out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
20.	Antisocial/Delinquent Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
21.	Running Away	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
22.	Somatic Complaints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
23.	Social Contact Avoidance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
24.	Property Damage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
25.	Theft	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
26.	Sexual Assault/Aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
27.	Threat to Life Of Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
28.	Poor peer interaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
29.	Extreme verbal abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
30.	Attentional difficulties/problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
31.	Non-compliance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
32.	Alcohol/substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
33.	Truancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
34.	Police contact	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
35.	Academic problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
36.	Poor self-esteem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Child's Name: _____

SECTION VI: CHILD EDUCATIONAL INFORMATION

18 A. Educational Placement (**check if present and/or in the past 12 months**)

- _____ 1. Regular Class in Age Appropriate Grade
- _____ 2. Regular Class, Retained at Grade Level _____
- _____ 3. Special Education – In-District Program/Services
- _____ 4. BOCES
- _____ 5. Day Treatment – Out of District (including OMH Day Treatment)
- _____ 6. Residential Program
- _____ 7. Vocational Training Only
- _____ 8. Part-time Vocational/Educational
- _____ 9. Not Enrolled in School
- _____ 10. High School Graduate/GED
- _____ 11. Home Instruction
- _____ 12. Bilingual Educational Services
- _____ 13. Other/Please Specify: _____

B. Name of School District _____

C. Name of School _____

D. Grade _____

19. Does this child have a condition which is classified by the Committee On Special Education

- | | | |
|--------------------------------|--------------------------------|-------------------------|
| _____ 1. Emotionally Disturbed | _____ 4. Physically Disabled | _____ 7. Not Classified |
| _____ 2. Learning Disabled | _____ 5. Other Health Impaired | _____ 8. Unknown |
| _____ 3. Sensory Impaired | _____ 6. Multiply Handicapped | |

20. School Behavior

- _____ 1. Does Not Participate
- _____ 2. Has Truancy/Attendance Problems/Cuts Classes
- _____ 3. Has Failing Grades
- _____ 4. Lacks Friends at School
- _____ 5. Assaults Teachers
- _____ 6. Does Not Respond to Teacher Demands
- _____ 7. Fights with Peers
- _____ 8. Frequent Suspensions

SECTION VII: SERVICE SUPPORTS INFORMATION

21. Child/Youth current or previous contacts with (check all that apply)

**Check if
EVER
received:**

**If received,
Supply dates:**

		A. Mental Health Services (Please Specify)
_____	_____	CCSI
_____	_____	Private Therapist
_____	_____	Clinic
_____	_____	CPEP
_____	_____	Staffing Pool
_____	_____	Day Treatment
_____	_____	Inpatient
_____	_____	Therapeutic Residential Program (2weeks)
_____	_____	HBCI
_____	_____	Family Support
_____	_____	Intensive Case Management
_____	_____	Waiver
_____	_____	Residential Treatment
_____	_____	Other (specify): _____
_____	_____	B. Number of Times Hospitalized for Mental Health: _____
_____	_____	C. Juvenile Justice
_____	_____	PINS DIVERSION
_____	_____	PINS
_____	_____	J.D.
_____	_____	D. Family Court
_____	_____	E. Child Welfare (If Yes, Please Specify)
_____	_____	Foster Care
_____	_____	Therapeutic Foster Care
_____	_____	Child Protective Services
_____	_____	Preventive Services
_____	_____	Family Preservation PACT
_____	_____	Other (specify): _____
_____	_____	F. Mental Retardation / Developmental Disabilities
_____	_____	G. Alcohol/Substance Abuse
_____	_____	H. Other (list Specific programs from F,G, &H): _____
_____	_____	_____
_____	_____	_____

Child's Name: _____

22. Current Community Contacts (Mental Health, DSS, Counselor, Probation Officer, School Representative, Others)

Agency or Organization	Name of Worker	Address	Telephone

23. Insurance and Financial Information (check all that apply)

- _____ 1. TANF Recipient
- _____ 2. Medicaid (without Public Assistance)
- _____ 3. Medicaid Managed Care
Company Name _____
- _____ 4. Medicaid Application Pending
- _____ 5. Medicaid Denied
- _____ 6. Medicaid Dependent on Hospitalization
- _____ 7. Private Third Party
Name of Insurer _____
- _____ 8. Child Health Plus
- _____ 9. Medicare
- _____ 10. No Insurance
- _____ 11. Earned Income
- _____ 12. Social Security/SSDI
- _____ 13. SSI
- _____ 14. Veteran's Benefits/Military
Benefits
- _____ 15. Paying out of pocket
- _____ 16. Other _____

24. Considering issues noted, describe your family's individualized care **needs**. (Please be as specific as possible):

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____

**CONSENT FOR RELEASE OF INFORMATION FOR
COMMUNITY SERVICES, OUT OF HOME PLACEMENTS & RTF**

Page 2: CONSENT TO RELEASE INFORMATION TO CONTINUUM OF CARE SUBCOMMITTEE

Signature of Parent/Legal Guardian,
or client of 18 years of age or older

Relationship

Printed Name Signed

Date Signed

Signature of Witness*

Title

Printed Name Signed

Date Signed

Signature of Person Completing Form
(Referent) *

Title

Printed Name Signed

Date Signed

*"Witness" and "Person Completing Form (Referent)" cannot be the same person.

=====

**PART II: RECORD OF INFORMATION RELEASED BY
TRANSITION COORDINATOR AND/OR PRIMARY CARE COORDINATOR**

Signature of Person Releasing Information

Transition Coordinator

Print Name Signed

Date Signed

RTF(s) Released To: _____

Date(s): _____

**ADDENDUM FOR
OUT OF HOME PLACEMENTS & RTF ONLY**

**CONSENT FOR RELEASE OF INFORMATION TO THE
COMMITTEE ON SPECIAL EDUCATION**

I authorize the Continuum of Care Subcommittee and Transition Coordinator to release the following information regarding _____ from the _____ school district:

- _____ Psychological Evaluation
- _____ Psychiatric Evaluation
- _____ Psychosocial History
- _____ Physical/Medical Evaluation
- _____ Other Relevant Assessments and Evaluations

Signature of Parent/Legal Guardian

Relationship

Print Name Signed

Date Signed

Signature of Witness

Title

Print Name Signed

Date Signed



**ADDENDUM FOR
OUT OF HOME PLACEMENTS & RTF ONLY**

REQUEST FOR DISABILITY DETERMINATION

I request the Continuum of Care Subcommittee (COCS) and the CNY Regional Preadmission Certification Committee to determine whether _____ is disabled for the purpose of the Medical Assistance Program. I submit this request in conjunction with an application for admission of the above named individual to a Residential Treatment Facility (RTF).

I authorize the COCS to review and evaluate any clinical and educational information it has received to assess whether the above name individual is disabled for the purposes of the Medical Assistance Program. I also authorize the COCS to make any investigation necessary to confirm or verify this information, or to collect additional information necessary to make disability determination.

If the above named individual is certified by the COCS as eligible for placement and referred to an RTF, I will be notified how to apply for Medical Assistance Benefits to help pay for the cost of the client's care while in care in the RTF. I understand that this form is not an application for Medical Assistance Benefits. I understand that the COCS will make the determination of whether the above named individual is disabled but not whether he/she is eligible for Medical Assistance. I also understand that the results of this disability determination will not affect any Medical Assistance benefits that the above named individual may currently receive.

Signature of Parent/Legal Guardian

Relationship

Print Name Signed

Date Signed

Mailing Address of Parent/Legal Guardian

Signature of Witness

Title

Print Name Signed

Date Signed

=====



STRENGTH BASED ASSESSMENT:

Tell me a little bit about your child...what does he or she like?

What are his/her favorites?

Foods:

TV Shows:

Sports:

School subjects:

Books / Movies:

Parents:

What are the **best** things about your family?

Who provides the most help to you and your family?

What things best help *you as parents* to cope during times of crisis and in stressful situations (e.g. humor, shopping, talking to someone)?

What things best help your *child* during times of crisis and in stressful situations? (e.g. go for a walk, to be left alone, restraint, divert attention)

What **doesn't** work:

Child: *(If present at interview)*

What do you like to do to have fun?

What are you good at?

Who are your close friends?

Why are they special to you?

CURRENT SITUATION INFORMATION:

What is happening now to make it difficult for your child to be at home?

If you had a magic wand, what would you change at home?

What would it take to make it happen?

PARENT PARTNER ACTIVITIES BEFORE CLOSE OF INTERVIEW:

Circle of Support: Fill out: **Get signature for consent to Tier 1 meeting**
Confidential Release form signed
Complete Child/Family Team form

I hereby give my consent to CCSI to plan a Tier 1 meeting for my child.

 Name(s) Date

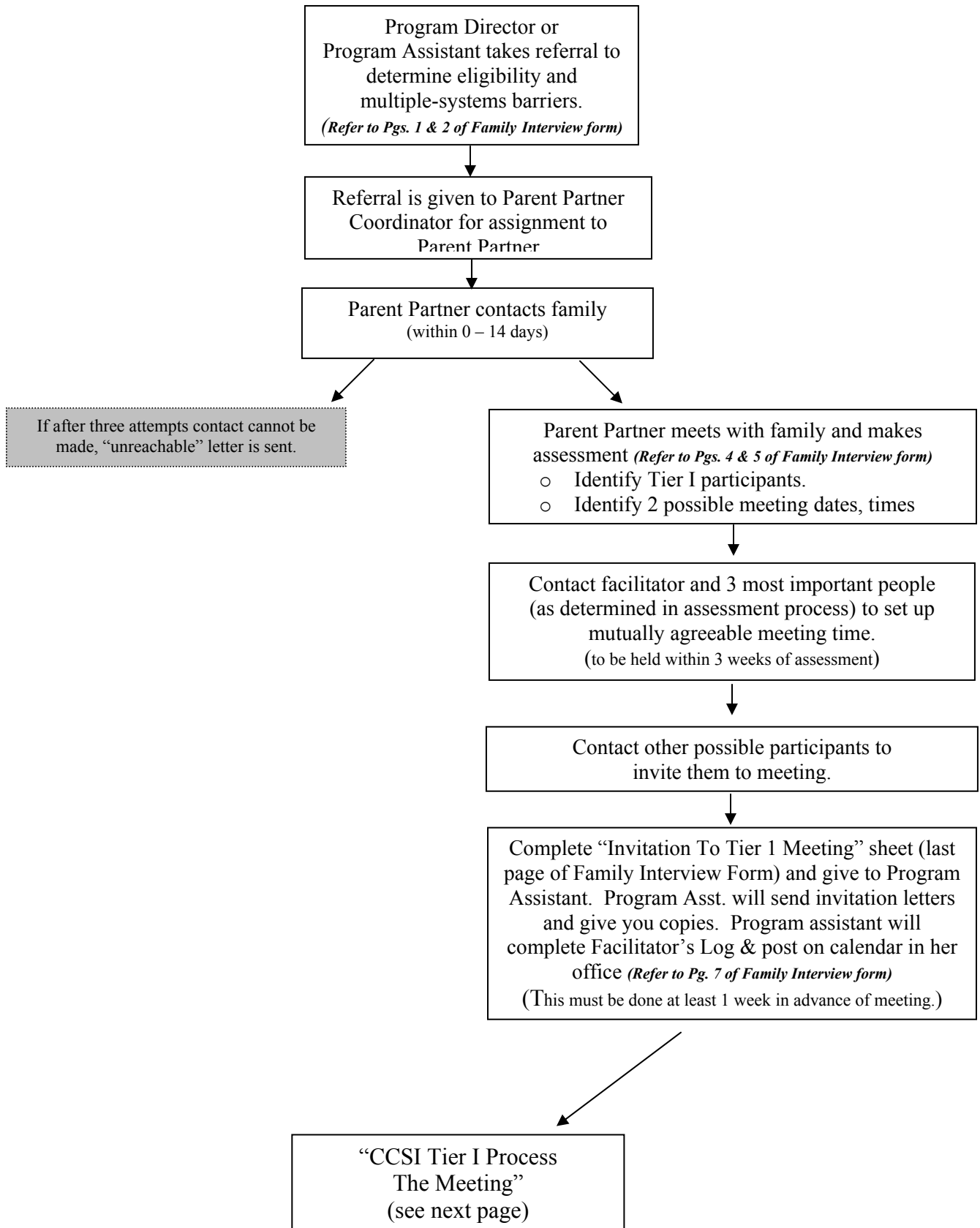
With parent(s), list family, friends, providers to be invited to meeting:
 (Get names, addresses and phone numbers)

Name:	Relationship	Address	Telephone	Who will contact

	1	2	3
Possible meeting dates:			
Possible meeting times:			
Possible meeting locations:			
Date of meeting:			
Meeting place:			

Further contact: 1] Leave CCSI Information Packet with business card.
 2] Arrange to be in contact to confirm meeting particulars.

CCSI Tier I Process: From Referral to Tier I Meeting



CCSI Tier I Process: The Tier I Meeting

1: Parent Partner brings supplies to meeting:

- Blank Family Plan Form
- Blank “Circle of Support” sheet
- Tissues
- Newsprint & Tape
- CCSI “Dear Colleague” Packets enough for each professional **not** already familiar with CCSI Process)
- Client Folder
- Blank Name Badges

2: Parent Partner to arrive 15 minutes prior to meeting start time.

3: Parent Partner sets up meeting room.

4: Parent Partner should always be seated next to the family.

5: Parent Partner should advise the facilitator upon their arrival of the plan follow up date. *(This should be scheduled by the Parent Partner for an office working day 2 weeks following Tier meeting.)*

6: Parent Partner begins the meeting by introducing herself, the family and child, and the facilitator. *She should continue by explaining: “The purpose of our Tier I meetings is to bring together agencies in our community to facilitate everyone working together, to create a specific plan to support our families as much as possible; and hopefully, to reduce the need for residential placements. This meeting is a process, of which the whole community should be involved...YOU are the process, and thank you all for coming.”*

7: Parent Partner circulates the “Circle of Support” sign-in sheet and name badges around the table, asking attendees to complete. *(When this comes back around to Parent Partner, she should make sure information is complete and legible.)*

(Do not delay the start of the meeting for late arrivals longer than 5 minutes after scheduled start time.)

8: Parent Partner to fill out the blank Family Plan form during the course of the meeting. (See “4” attached) *Please keep it legible.*

9: To enhance community buy-in of the plan, the Parent Partner should not be a part of the plan if at all possible.

10: Thank everyone for their participation at close of meeting. Facilitator will advise team of the follow-up date

◆*Do all possible to keep the meeting to 1 hour in duration.*

AFTER THE MEETING:

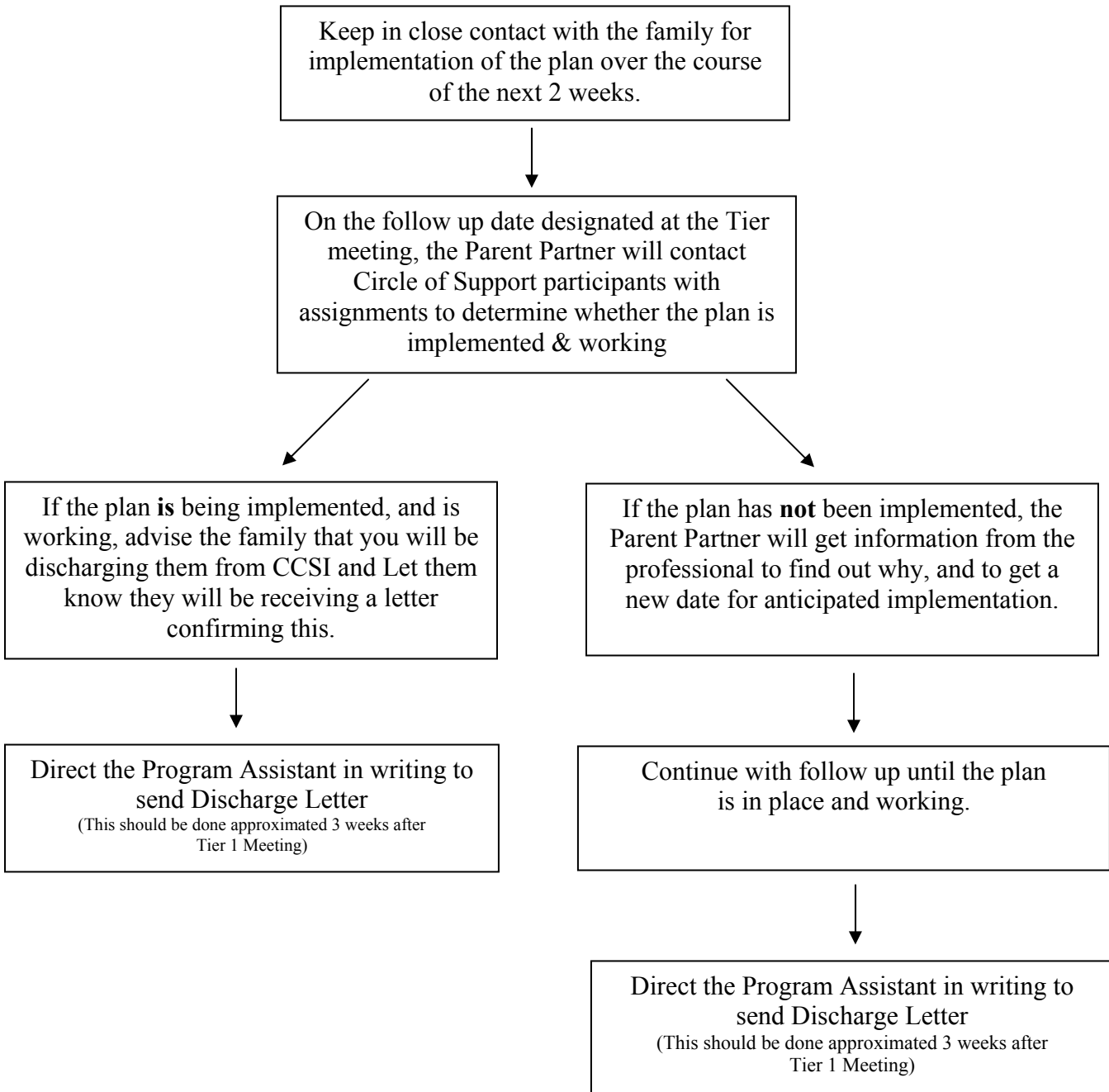
1: Bring the “Circle of Support” and completed “Family Plan Form” to the Program Assistant. She will word process both, and use the Circle of Support to create an electronic file and mailing list for the plan to the attendees.

2: A standardized ‘family plan meeting letter’, thanking the attendees, will be created for each person present, and a copy of the processed circle of support and family plan will be attached. You will be given copies. *(These will be done within 1 week of the meeting.)*

↓
Post-Tier Follow Up
(see next page)



CCSI Tier I Process: Post-Tier Follow Up





Section G

Training Sign-Off Sheets

Step 1 Training Sign-Off - Pgs. 1 & 2

Step 2 Training Sign-Off – Pg. 3



SECTION G - TRAINING SIGN-OFF SHEET

Page 1

STEP 1

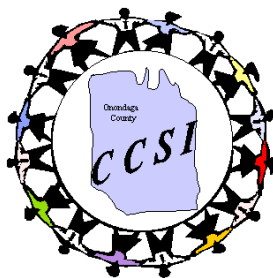
Trainee – Please initial in each box. In doing so, you acknowledge receiving the training for stated topic:

- SECTION B & C – VIDEO AND CODE OF ETHICS
- SECTION D – OFFICE PROCEDURES
- WRAP-AROUND THEORY – INDIVIDUALIZED AND TAILORED CARE
- STRENGTHS MODEL vs. DEFICIT MODEL
- CASSP PRINCIPLES
- TIERS OF CCSI and ACRONYMS
- IDENTIFYING AND ISOLATING ISSUES – Yours/ Your Client's
 - a) The "I STORY"
 - b) "I Stories": Practical Application
 - c) Healthy Boundaries
- RESTORING A FAMILY'S FAITH
- LISTENING TO YOUR INTUITION
- SCOPE OF CCSI
- FOCUS ENERGY – Prioritizing
- YOUR ROLE AS AMBASSADOR: FAMILY & COMMUNITY
- PART OF A TEAM AND AN EQUAL PARTNER
- PROTECTING THE INTEGRITY OF CCSI
- TAKING CARE OF YOURSELF
- YOU CAN'T PLEASE EVERYONE: The Reality

Trainee Signature

Date Training Completed

Signature of Educational Coordinator



SECTION G - TRAINING SIGN-OFF SHEET

Page 2

STEP 1

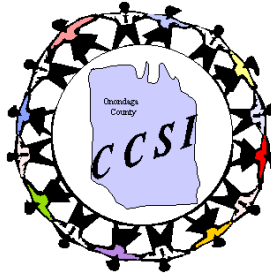
Trainee – Please initial in each box. In doing so, you acknowledge receiving the training for stated topic:

- CONDUCTING THE STRENGTH BASED ASSESSMENT
- HOME VISITS
- CULTURAL COMPETENCY
- CREATING A NETWORK
- HOW TO ENGAGE RESISTIVE FAMILIES
- SENSITIVITY TO HIGH PROFILE CASES
- HOW TO FIND REFERENCE MATERIALS
- HOW TO IDENTIFY AND INITIATE SYSTEMS CHANGES
- HOW SOCIAL POLICY EFFECTS YOUR WORK

Trainee Signature

Date Training Completed

Signature of Educational Coordinator



SECTION G - TRAINING SIGN-OFF SHEET

POLICIES & PROCEDURES

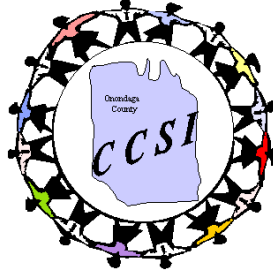
Trainee – Please initial in each box. In doing so, you acknowledge receiving the training for stated topic:

- Parent Partner Time Sheet Reporting
- Conference and Workshop Attendance
- Community Wrap-Around Funding
- CCSI Statistics
- Referral Procedures
- Tier 1 Process
- Conducting a Strength Based Assessment
- Closing a Client File
- Home Visits
- Protocol in Dealing With Service Providers

Trainee Signature

Date Training Completed

Signature of Parent Partner Coordinator



SECTION H

REFERENCE MATERIALS LISTING

- Curriculum**
- Pay Schedule**
- Family's Together Newsletter (most current issue)**
- Federation of Families for Children's Mental Health
(Informational sheet & membership form)**
- Youth Services Directory (Feb. '98)**
- OCM BOCES School Administrative Directory (2000-01)**
- United Way Human Services Directory (2000)**
- PPYD's SCSD Referral Cross Reference
(Directory of Universal, Selected and Indicated Services)**
- Continuum of Community Based Mental Health Services**



SECTION I

TRAINING EVALUATION

What was positive for you about the way the training was presented? The curriculum
 The trainers

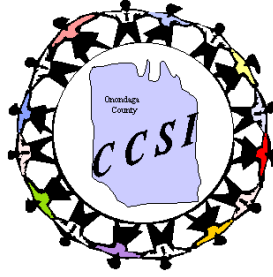
What would you change?

What was least beneficial about this training?

Was the information sufficient to give a good understanding of the topics?

Was the information presented in an interesting format? (organized? varied?)

Other comments: *(your feedback is appreciated!)*



SECTION J

Contributors

-

About The Authors

Contributors

The staff at Onondaga County Coordinated Children's Services Initiative wishes to thank John VanDenBerg and Mary Grealish for their work on Family Strengths and Wrap-around Process. It has truly laid the foundation for our work.

Gratitude goes to Barbara Friesen, Ph.D. and Nancy Koroloff, Ph.D. for their efforts in the early 1980's that created a framework for a newer, efficient and friendlier system of care. They helped us to shift from a child centered approach to family centered care.

Jane Knitzer's 1982 research helped to bring attention to the fact that almost half of the United States did not have a special mental health focus for children. This new system, of course, is known as the *Child and Adolescent Service System Program* (CASSP), which focuses on this research.

We are appreciative of the work of Betsy Crane and Christiann Dean for their efforts developing the *Empowerment Skills for Family Workers*, which is used to supplement this curriculum.

We acknowledge the Community Resource Consortium (1994), for their piece on *Reframing Common Terms*, which we have modified.

Peck, Scott. M., M.D. *The Road Less Traveled and Beyond* for inspirational thoughts.

Maslow's Hierarchy of Needs diagram adapted from *Themes and Variations*, Wayne Weiten (1995).

Excerpts from *Safe and Sound: Caseworker Safety in the Delivery of Social Services*, by the Institute for Families and Children.

We are also thankful to the unknown author of the poem "*The Winner*", as well as the unknown author of "*Letting Go*".

For more information about this curriculum contact:

Onondaga County Coordinated Children's Services Initiative
Onondaga Case Management Services
220 Herald Place – 3rd Floor
Syracuse, NY 13202
(315) 472-7363

About The Authors

Nancy Allen

Nancy is a CCSI Parent Partner site positioned at McCarthy School in the Syracuse City School District. She is currently involved in facilitator training for CCSI's Parent Support Group. She has been working as a Parent Partner for about a year, and has shown great success at getting parents more involved in their children's lives.

Marilyn Colletta

Marilyn began her advocacy for parents of special needs children in the early 1990's as a result of having difficulty with her own child and with the encouragement of Families Together of New York State. When CCSI was forming in Onondaga County in 1996, she was hired to work in partnership with professionals to help engage parents of children who were at risk of placement. She called herself a Parent Partner, and the legacy continues. Marilyn is now Educational Outreach Coordinator for CCSI. She is also on the Board of Directors for Families Together of New York State; is a member of the Onondaga County Mental Health Subcommittee and Co-founder of the Central NY Families Support Coalition.

Marge Krom

A new addition to CCSI as Parent Partner and is in training to become a facilitator at CCSI's Parent Support Group. Marge is site positioned at Hillside Children's Center. She is proud and pleased to be a member of these teams.

Nancy Kuss

Nancy is a seasoned veteran of the Coordinated Children's Services Initiative in Onondaga County. She has been with CCSI since its inception in 1996 as a Parent Partner, and recently became Parent Partner Coordinator, and has many years of personal experience with dually diagnosed children. Nancy co-facilitates the CCSI Parent Support Group, which she helped create.

Kelly Warren

Kelly relocated to Utah in 2001. She was the pioneer of "site positioning" for Parent Partners in Onondaga County. She was active in CCSI's Parent Support Group and we thank her for sharing her wonderful writing skills with us in the development of this curriculum.

Cathy Munson

Our newest Parent Partner Trainee, brought "fresh eyes" and lent her invaluable proof-reading and editing expertise to the finalization of this document.