Greene County Family and Children First High-Fidelity Wraparound Program Referral

Date of Referral:	**Person referring:**
Agency:	**Phone number:**
Email:	

Youth's Name In Home (List referred youth first)	Sex	DOB	Adopted Y/N	School	Grade

Other individuals in home	Sex	DOB	Relationship to child

Parent/ Legal Guardian Information:	
Name:	**Name:**
Address:	**Address:**
City/State/Zip:	**City/State/Zip:**
Phone Number:	**Phone Number:**
Email:	**Email:**
Employer:	**Employer:**

Family's Gross income from ALL sources: _____

Source of Income/Support (Circle all that apply)

Employment SSDI (Disability) SSI Child Support TANF/ADC Social Security Greene Met

Food Stamps WIC BCMH Medicaid Waiver Adoption Subsidy PASSS Funding

Insurance Information:

Does the family receive Medicaid/Medicaid Managed Care? Y or N

If so from whom:_____

Medicaid Provider IE: Buckeye, Caresource, Molina Healthcare

Does the family have an employer-sponsored insurance plan? Y or N

Employer:_____

Insurance Company:_____

***Please provide a copy of current insurance card**

Does this youth have a history of abuse? Physical Sexual Neglect

Please describe a brief history to support this: _____

_____

_____

_____

Is the youth out of the home currently (hospital, detention, treatment facility)? Y or N

Where and for how long: _____

_____

GREENE COUNTY FAMILY STABILITY PROGRAM INTER-SYSTEM
CONSENT FOR RELEASE OF INFORMATION

Name of Person	Social Security Number	Date of Birth
Parent/Guardian	Address	Phone Number
Referring Agency	Contact Name	Phone Number

The following agency(s) and/or provider(s) have my permission to exchange/give/share/disclose information as indicated below regarding service information for the purpose of securing, coordinating, planning and/or providing services for the above-named person. (Please identify all agencies that apply, then initial next to each check mark.)

___Help Me Grow
___Council on Rural Services
___Greene County Children Services
___Greene County Dept. of Job & Family Services
___Greene County Combined Health District
___Greene County Family & Children First
___Greene County Juvenile Court
___Greene County ESC & L.C.
___Greene Academy
_____

___Greene County Board of Dev. Disabilities
___School District: _____
___TCN Behavioral Health Services
___TCN/Family Solutions Center
___Mental Health & Recovery Bd. of Greene Co.
___CASA
___Parent Advocacy Connection
___Miami Valley Juvenile Rehab. Center
___ _____
_____

The information I am authorizing these agencies to exchange/give/share/disclose, if needed, is indicated below. (Indicate Yes, No, or NA in the column below, then initial by each.)

Circle One	Initial	
Yes NA No	____	Identifying Information: name, birth date, sex, race, address, telephone number, social security number
Yes NA No	____	Greene County Cluster/Diversion/Family Stability Information: reports, plans, relevant family information, progress notes
Yes NA No	____	Case Information: the above identifying information plus social history, treatment/service history, psychological evaluations, psychiatric reports and evaluations, Individualized Educational Plans, treatment/service plans, Individualized Family Service Plans, transition plans, vocational assessments, COEDI, grades and attendance, and other personal information regarding me or the individual named above (disability, type of services to me or the individual named above). Information regarding HIV/AIDS and/or substance abuse diagnosis and treatment shall not be released unless a "Yes" is indicated and an initial placed below:
Yes NA No	____	HIV and AIDS related diagnosis and treatment
Yes NA No	____	Substance abuse diagnosis and treatment
Yes NA No	____	Financial Information: public assistance eligibility and payment information provided for establishing eligibility including but not limited to pay stubs, W2s and tax returns, and other financial information.

This information will remain in effect for 180 days after I sign this date unless I specify an earlier expiration date in this space: _____. The revocation does not include information that has been shared between the time that I gave permission to share information and the time it was cancelled. I understand that my records are protected under the federal regulations governing confidentiality of alcohol and drug abuse. Federal regulations (42 CFR Part 2) prohibits you from making further disclosure of it without my specific written consent. Federal rules restrict any use of information to criminally investigate or prosecute for any alcohol or drug abuse client.

This consent expires on the _____ day of _____, 20_____.

_____ _____
Signature of Person (Age 16 and older) Date

_____ _____
Signature of Parent/Guardian Date

_____ _____
Witness/Agency Representative Date

* * * * * * * * * * * * * * * *

Revocation of Authorization of Release of Information

I hereby revoke this authorization.

_____ _____
Signature of Person Date

_____ _____
Signature of Parent/Guardian Date

_____ _____
Witness/Agency Representative Date

A violation of Federal law regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

TO ALL AGENCIES REVEIVING INFORMATION DISCLOSED AS A RESULT OF THIS SIGNED CONSENT:

1. If the record released include any information of any diagnosis or treatment of drug or alcohol abuse, the following statements apply: Information disclosed pursuant to this consent has been disclosed to you from records whose confidentiality is protected by law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.
2. If the records released include information of an HIV-related diagnosis or test results, the following statement applies: This information has been disclosed to you from confidential records protected from disclosure by state law. You shall make no further disclosure of this information without the specific, written and informed release of the individual to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for the release of HIV test results or diagnoses.
3. The information has been disclosed to you from records protected by federal and/or state confidentiality rules. Any further releases of it is prohibited unless the person to whom it pertains. DYS in the case of youth records, or applicable federal and/or state law, expressly permits the further disclosure.

Approved by: Expanded Cluster/Diversion Committee – 1/23/98
Revised: 1/03, 2/06, 12/09, 8/10

Criteria for All Cluster Meeting

Please provide the following information and a short case history for each child you are referring for cluster or service coordination. This information is needed before any meeting will take place to discuss placement or residential treatment options. If therapist or psychiatrist is recommending placement please provide a written letter from them prior to this meeting.

1. Has the youth been in good solid Mental health treatment or AOD services for at least 4 months?
   a. If no, what barriers are in the way of this service?
   b. If yes, what are the recommendations of the mental health therapist?

2. Has the youth seen a psychiatrist about Mental Health issues?
   a. If no, was this recommended by therapist?
   b. If yes, did the family follow through with all recommendations?

3. Does the youth have criminal charges? What are the charges and the outcomes?
   a. If no, skip this question
   b. If yes, provide a list of both current and pending charges and the outcomes.

4. Is the youth on probation?
   a. If no, skip this question
   b. If yes, are they following the rules of probation? If they are not following the rules of probation what action is being taken?

5. Does the youth have a diagnosis of Development delays?
   a. If no, skip this question
   b. If yes, where from and please provide documentation?

6. Is the youth receiving services from the BODD?
   a. If no, skip this question
   b. If yes, who is the case manager or is the child on the waiting list for services?

7. Is the youth receiving special educational service or on an IEP?
   a. If no, skip this question
   b. If yes, please provide a copy to the team prior to meeting.
   c. Does the youth have behavioral issues at school?
   d. What are the youth's grades?

8. Would respite, ABA therapy, in home counseling, parenting, parent mentoring, intervention services or educational services prevent this child from being removed from their home? Is there any other service that this family needs that is not available in our county?

Please complete the following Release of Information for each youth to be discussed in the meeting. Meetings will not be scheduled before team receives permission to discuss youth and obtain any necessary information that may be needed to contact the family and service providers.

Check all that apply below:

Current Youth Involvement (Last 30 days)			
☐ Juvenile Court	☐ IEP	☐ Probation/Parole	☐ Health Department
☐ Child Welfare Services	☐ Special Education Class	☐ Psych Hospitalization	☐ Head Start
☐ Mental Health Agency	☐ Alternative School	☐ Medicaid Recipient	☐ Help Me Grow
☐ MR/DD	☐ GRADS Program	☐ Receives SSI Benefits	☐ Substance Abuse Program
☐ OWF - Welfare			
Other: ☐			

Known Presenting Risks		
☐ Suicidal Ideation, Gestures, Attempts ****Requires crisis/safety plan****	☐ Depression - Current or History	☐ Resides in High Crime Neighborhood
☐ Self Injurious Behavior	☐ Hears Voices/Sees Things	☐ Prejudicial Thinking/Ideation
☐ Violent Behaviors (Towards Others, Animals Property, etc) ****crs/safe plan****	☐ Impulsive Behavior	☐ Unrestricted Internet Access
☐ Fire Setting - Current or History	☐ Anorexia/Bulimia	☐ Lack of Caregiver Monitoring and/or Supervision
☐ Runaway - Current or History	☐ Victimization: Physical, Emotional or Sexual	☐ Acute Family Crisis
☐ Chargeable for Sex Offense ****Requires crisis/safety plan****	☐ Sexual Acting Out/Impulsivity - Current or History	☐ Family Conflict
☐ Aggressive Behaviors (Towards Animals, Property, Others, etc)	☐ Youth Uses Drug or Alcohol	☐ Youth's Lack of Stable Residence/Homeless
☐ Verbal or Written Threats to Others	☐ Negative Peer Involvement and/or Gang Activity	☐ Current Placement/Suspected Child Abuse
☐ Suspended, Expelled or Dropped Out of School	☐ Parent w/Chronic/Acute Mental Illness, Developmental Delay, MR	☐ Truancy
☐ Known/Suspected Criminal Activity	☐ Parent w/Drug or Alcohol Problem	☐ Limited Ability to Control Anger
☐ Availability of Weapons	☐ Parent w/Severe Chronic Illness	☐ Emotional or Educational Disabilities
☐ Limited Developmental Capacity to Maintain Personal Safety	☐ Held Back/Behind in Grade	

Information Source (Name): _____ Relationship: _____

At: _____ Intake By: _____

Parental Contribution Assessment worksheet for

Residential Services

Child's Name:	DOB:
Mother's Name: SSN: Address: City/State/Zip Code:	
Father's Name: SSN: Address: City/State/Zip Code:	
Please use the procedure on the back of this sheet to determine Parental Contribution	
Monthly Parental Contribution (use amount determined on back)	
This is to acknowledge that all of the income information provided is accurate to the best of my knowledge, that the fee assessment process has been explained to me, and that I agree to pay assessed fees by the 5th of the following month. *EX: January 2019 bill would need to be paid by February 5th, 2019* **I understand that services can be discontinued for non-payment if adequate arrangements are not made with my case manager at Family and Children First.** **I will discuss any problems that arise about making payments as agreed to above with my case manager at Family and Children First.** **If I do have insurance, I understand that I must request insurance payment for all mental health services prior to accessing shared funding.** **If I receive Supplemental Security Income (SSI), Social Security (SSA), or other funding on behalf of the child, I shall immediately inform funding source when the child is moved to residential placement.**	
Mother's Signature **Date**	**Father's Signature** **Date**
Case Manager's Signature **Date**	**Director Signature** **Date**

The taxable Income, as verified on the most recent 1040 Tax Form, is used to determine the Parental Contribution. Please Note: When the most recent 1040 Tax Form is not available or the legal guardian/parent's income has change dramatically, use 3 months of the most recent pay stubs. Determine an average weekly gross income and multiply by 52 weeks. If the parents filed separate tax forms, both 1040 forms are needed and will be considered to determine the parental contribution.

If a joint return was filed, please use this box to determine the Parental Contribution	
List in A.) the annual taxable income from the most recent 1040. If AGI is $15000 or less skip to C.) and enter (0)	A.)
Multiply the amount in A.) by 3%. List this amount in B.)	B.)
For C.), divide the amount in B.) by 12. This is the Monthly Parental Contribution to be used on the front of this form.	C.)

If there are separate returns, complete each section for the mother and father.

Mother:	
List in A.) the annual taxable income from the most recent 1040. If AGI is $15000 or less skip to C.) and enter (0)	A.)
Multiply the amount in A.) by 3%. List this amount in B.)	B.)
For C.), divide the amount in B.) by 12. This is the Monthly Parental Contribution to be used on the front of this form.	C.)

Father:	
List in A.) the annual taxable income from the most recent 1040. If AGI is $15000 or less skip to C.) and enter (0)	A.)
Multiply the amount in A.) by 3%. List this amount in B.)	B.)
For C.), divide the amount in B.) by 12. This is the Monthly Parental Contribution to be used on the front of this form.	C.)

If the parent's do not agree with the Monthly Parental Contribution, they should not sign this form. The High-Fidelity Wraparound team will need to meet to consider and agree upon an <u>adjustment</u> to the Monthly Parental Contribution.

GREENE COUNTY FAMILY AND CHILDREN FIRST
FAMILY STABILITY PROGRAM

SHARED FUNDING REQUEST CONFIRMATION

TO (PARTNER AGENCY): _____

CHILD / YOUTH NAME: _____ DOB: _____

PARENT / GUARDIAN NAME: _____

The Greene County Family and Children First Wrap-around team has met regarding the above-named family / child and has made recommendations and is seeking shared funding for the following services and amounts:

Please indicate your agency's ability / willingness to participate in shared funding as requested.

_____ Yes, _____ will participate in funding of the above-mentioned services.

_____ No, this agency is not able to commit to funding this service at this time. We make the following recommendations for services we may be able to provide to support this family in lieu of funding:

_____

_____

_____

Signature: Date:

_____ _____

Printed name: _____ Title: _____