Family Voices Network of Erie County

Referral Process Form

Family Voices Network of Erie County
Attn: Elizabeth Benitez
478 Main St., 2nd Floor, Buffalo, NY 14202
Telephone: (716) 858-2192 – Fax: (716) 858-7492

REFERRAL DATE: _____

IMPORTANT NOTE: This application cannot be processed unless **ALL** portions are Legible and complete. PLEASE PRINT CLEARLY OR TYPE.

Referred Youth's Information

First Name:	MI:	Last Name:		
Date of Birth:	Gender:	Race:	Social Security Number:	
Primary Language:	Secondary Language:			
Address:	City:	County:	State:	Zip code:
Home Phone:	Other Phone:	☐ Refugee ☐ Immigrant		
Is youth enrolled in a Health Home ☐ Yes ☐ No	Name of Health Home:	Name of Care Manager: Phone:		

Parent or Guardian Information

First Name:	MI:	Last Name:	Relationship to Youth:
Primary Language:	Secondary Language:		☐ Refugee ☐ Immigrant
Address:	City:	State:	Zip code:
Home Phone:	Work Phone:	Other Phone:	
Is Parent enrolled in a Health Home ☐ Yes ☐ No	Name Of Health Home:	Name of Care Manager: Phone:	

Parent or Guardian Information

First Name:	MI:	Last Name:	Relationship to Youth:
Primary Language:	Secondary Language:		☐ Refugee ☐ Immigrant
Address:	City:	State:	Zip code:
Home Phone:	Work Phone:	Other Phone:	
Is Parent enrolled in a Health Home ☐ Yes ☐ No	Name Of Health Home:	Name of Care Manager: Phone:	

Referral Source Information

Referral Source Name:	Agency:	Title:
Address (Number, Street, City, State, Zip):		
Phone:	Fax:	Email:
Supervisor Name:	Supervisor Phone:	Supervisor Email:

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Type of Referral

Referral Type (Must select one):

☐ Community-Based High Fidelity Wraparound ☐ RTC/CC ☐ PACC – RTF ☐ Community Residence

Is referral type related to Child Welfare? ☐ **Yes** ☐ **No**

Is referral type related to Juvenile Justice? ☐ **Yes** ☐ **No**

Youth Information

Youth's Supervision at Home

☐ Two Parent Family
☐ One Parent Family
☐ Adoptive Two Parent Family
☐ Adoptive One Parent Family
☐ Grandparents
☐ Family Friend
☐ Other Relative's Home _____
☐ OCFS/DSS Family Foster Care
☐ Other

Youth Living Situation at Time of Referral

☐ Home
☐ Group Home (DSS/OCFS)
☐ Therapeutic Foster Care
☐ Family Foster Care (DSS/OCFS)
☐ Respite Bed (Paid Vendor Only)
☐ Runaway Shelter/Homeless
☐ Crisis Bed (i.e. Compass House)
☐ AWOL
☐ Family Based Treatment
☐ Residential Treatment Center (DSS/OCFS)
☐ Residential Treatment Facility (OMH)
☐ Community Residence (OMH)
☐ WNYCPC
☐ Inpatient Psych Hospitalization _____
☐ Inpatient Substance Abuse _____
☐ Non-Secure Detention
☐ Secure Detention
☐ Holding Center
☐ Inpatient Medical Hospitalization
☐ Other _____
☐ Supervised Independent Living Program (SILP)

Name of Placement Agency:

Discharge Date (If applicable) _____/_____/_____

Medicaid Eligible?

☐YES ☐NO

CIN# _____

Recipient of in the last 6 months?

☐ Medicaid
☐TANF
☐Child Health Plus
☐Social Security Survivor Benefits
☐(SSI Benefits) Social Security Disability
☐Private Insurance
☐ Other (specify) _____

Household-Family Composition

(Other than referred youth & guardians)

First Name	Last Name	Gender M/F	Date of Birth (dd/mm/yy)	Relationship to Youth	Living with Identified Youth? (If no, with whom?)	Currently Involved in Care Coordination? (Yes or No)	Other services in place? (Specify)

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Past System Involvement of Youth *(Select all that apply)*

System	Agency	Phone #	Contact Person
☐ Juvenile Justice (FST/JDST/Probation)			
☐ Active in Court			
☐ Mental Health Agency/Clinic/Provider			
☐ Hospital			
☐ Erie County Department of Social Services			
☐ Other (Please specify)			

Current System Involvement *(Select all that apply)*

System	Agency	Phone #	Contact Person
☐ Juvenile Justice (FST/JDST/Probation)			
☐ Active in Court			
☐ Mental Health Agency/Clinic/Provider			
☐ Hospital			
☐ Erie County Department of Social Services			
☐ Other (Please specify)			

Targeted System Trajectory Risks

Family

Rate likelihood of system penetration due to this concern (MUST CHOOSE ONE) ☐ **High** ☐ **Medium** ☐ **Low**

Aggression? ☐ YES ☐ NO If yes, towards whom? _____

Parent/Youth Conflict? ☐ YES ☐ NO

Conduct/Oppositional Behavior? ☐ YES ☐ NO

Explain:_____

_____

_____

_____

_____

Runaway

Rate likelihood of system penetration due to this concern (MUST CHOOSE ONE) ☐ **High** ☐**Medium** ☐**Low**

Leaving without permission? ☐ YES ☐ NO ☐ Past ☐ Present

Is youth running to or from home? (Specify) _____

Curfew Violations? ☐ YES ☐ NO ☐ Past ☐ Present

About how long does youth stay out past curfew? _____

Runaway Warrant Filed? ☐ YES ☐ NO ☐ Past ☐ Present

Missing Persons Number (Not required) _____

Explain: _____

_____

_____

_____

_____

Substance Abuse

Rate likelihood of system penetration due to this concern (MUST CHOOSE ONE) ☐**High** ☐**Medium** ☐**Low**

Frequency/Drug of choice? _____

Substance Abuse Treatment? ☐ YES ☐ NO ☐ Past ☐ Present

Inpatient Treatment? ☐ YES ☐ NO ☐ Past ☐ Present

Explain: _____

School

(Check all that apply & specify below)

Rate likelihood of system penetration due to this concern (MUST CHOOSE ONE) ☐**High** ☐**Medium** ☐**Low**

School Contact: _____ Phone Number: _____

Select all that apply:

☐ Repeated Grades ☐ Aggression ☐ Failing/Failures ☐ Truancy

☐Suspensions ☐ Drop Out ☐ Special Education ☐ Pervasive Developmental Disability/OPWDD

Explain:_____

Mental Health

(Check all that apply & specify below)

Rate likelihood of system penetration due to this concern (MUST CHOOSE ONE) ☐**High** ☐**Medium** ☐**Low**

☐ Hospitalizations (past)
☐ Hospitalizations (present)
☐ CPEP (past)
☐ CPEP (Present)
☐ Any suicidal or self-injurious behavior(s)
☐ Mental Health history/diagnosis/ treatment
☐ Psychotic Behaviors (hallucinations/delusions/ odd behaviors)
☐ Enuresis/Encopresis (involuntary urination/stool holding)
☐ Eating Disorder
☐ Trauma (sexually acting out/cruelty to animals/domestic violence/abuse/traumatic grief/adjustment related problems)

Explain:_____

Community Behaviors

(Check all that apply & specify below)

Rate likelihood of system penetration due to this concern (MUST CHOOSE ONE) ☐**High** ☐**Medium** ☐**Low**

☐ Delinquent peer groups ☐ Gang involvement/affiliation ☐ Aggression ☐ No peer involvement ☐ Stealing

☐ Property Damage ☐ History of fire setting ☐ Police involvement ☐ Legal History ☐Past ☐Present

Explain:_____

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Court Involvement

(Check all that apply & specify below)

☐ Family Court ☐Past ☐Present
☐ Criminal Court ☐Past ☐Present
☐ Charges ☐Past ☐Present
☐Formal Juvenile Probation ☐Past ☐Present
☐ Family Services Team ☐Past ☐Present
☐ JDST/Appearance Ticket ☐Past ☐Present

Explain:_____

Other System Involvement

(Check all that apply)

☐ Child Protective Services ☐Past ☐Present
☐ Preventive Services/DSS ☐Past ☐Present
☐ Foster Care ☐Past ☐Present
☐ OPWDD Eligible
☐ History of Placement ☐ RTC ☐ RTF
☐ Other (Specify below)

Explain:_____

School Information

Placement Type: ☐ Regular School ☐ Home Schooled ☐ By Parent ☐ By District ☐ Not Enrolled

School Type: ☐ Public School ☐ Private School ☐ Alternative Placement ☐ Day Treatment ☐ Day School ☐ BOCES

School District:

School Name:

Current Grade:

Special Education (Check all that apply):
☐ Learning Disabled ☐ Emotionally Disabled ☐ IEP
☐ 504 Plan ☐ 15:1:1 ☐ 12:1:1 ☐ 8:1:1 ☐ 6:1:1

Are any of the following a current issue/concern?

Attendance? ☐Yes ☐ No
If yes, please specify why: _____

Previous Grade Retention(s)? ☐ Yes ☐ No
If yes, which grade(s): _____

Suspensions? ☐ Yes ☐ No
If yes, please specify why youth was suspended: _____

Medical Information

DSM Diagnosis Source **(provided within last 12 months preferably)**

Which professional source made the diagnosis as indicated in the following information below?

☐ Child Psychiatrist ☐ Licensed Clinical Social Worker ☐ Child Psychologist
☐ General Psychiatrist ☐ Nurse Practitioner ☐ General Psychologist
☐ LMHC ☐ Primary Physician ☐ Other _____

Name of Clinician:	**Date of Diagnosis:**

DSM Diagnosis Information

AXIS I DIAGNOSIS: CLINICAL DISORDERS (*Please list Axis 1 Primary Diagnosis first*)

AXIS II DIAGNOSIS: PERSONALITY DISORDERS, MENTAL RETARDATION (If any)

AXIS III DIAGNOSIS: GENERAL MEDICAL CONDITIONS (If any)

AXIS IV DIAGNOSIS: PSYCHOSOCIAL AND ENVIRONMENTAL PROBLEMS
(*Select all that apply*)

☐ Problems with primary support group ☐ Economic problems
☐ Problems related to the social environment ☐ Problems with access to health care services
☐ Educational problems ☐ Occupational problems
☐ Other psychosocial and environmental problems ☐ Housing problems
☐ Problems related to interaction with the legal system/crime

AXIS V DIAGNOSIS: GLOBAL ASSESSMENT OF FUNCTIONING (GAF)

ENTER GAF SCORE:	**Important**: The child or youth GAF score must be under 50 to qualify as a serious emotional disturbance (SED).

If there is no diagnosis available, please list any parental concerns regarding potential diagnoses:

_____
_____
_____
_____

Please list any medications the youth is currently taking:

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Care Coordination/Wraparound/ SPOA Process Authorization Form

To be completed by Parent/Guardian Only

My Voice, My Choice:

Family Voices Network (FVN) of Erie County recognizes that families have a voice and choice while enrolled in Care Coordination services. I, as the parent/caregiver, understand my family's strengths and needs are identified during our enrollment in Care Coordination services. I also plan to work with a team of people to help create a Plan of Care that will work best for my family.

I acknowledge my family will receive services from one of the Care Coordination agencies listed below and that I also have a choice to identify an agency that I do not want to work with.

Please check one choice below:

☐ NO agency preference based on the list below

☐ I prefer to be assigned to: _____

(Please be aware that by choosing this option it may delay your assignment for services.)

1. Child & Adolescent Treatment Services (CATS)
2. Child & Family Services, Inc. (CFS)
3. Gateway-Longview
4. Mid-Erie Counseling & Treatment Services
5. New Directions Youth & Family Services

Parent/Guardian Name (please print): _____

Signature: _____ Date: _____ Phone: _____

For Referral Source Submitting this Referral Application:

Below is a list of required forms to expedite this application. By signing below, you indicate that you have included all the necessary forms/documentation for this family's application for Care Coordination services. Please check all that are included in the total referral submission.

	Permission to Use & Disclose Confidential Information (form attached to FVN Referral Application)
	Parent/Caregiver Authorization for Referral of Services (listed above)
	Copy of the Psychiatric Evaluation (within last 12-months) if available
	Copy of the "Discharge Plan" if youth is in placement or hospital

I confirm that the information submitted in the referral application is reflective of the current status of the family.
I will ensure the FVN Referral Application and supporting documentation is submitted to FVN within 48-hours of the parent/guardian signature listed above.

By signing application I assert referral is complete and Care Coordination services were explained to the family.

Your Name (Print): _____ Agency/Department: _____

Address: (Print address, city, state, and zip code) _____

Your Signature: _____ Date: _____

Email Address: _____ Telephone Number: _____ Fax Number: _____

Supervisor/Program Director Name: _____

Phone: _____ Email Address: _____

Pertaining to Which System? (Circle One) Juvenile Justice, Mental Health, Social Services, School, Family, System of Care, Other

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CONSENT FORM

Permission to Use and Disclose Confidential Information

Important: Both pages of this agreement must be submitted with the Referral Form. If not, the referral form will be returned as we cannot process the application without the confidentiality disclosure and appropriate signatures.

This form is designed to be used by organizations that collaborate with one another in planning, coordinating, and delivering services to persons diagnosed with mental disabilities. It permits use, disclosure, and re-disclosure of confidential information for the purposes of care coordination, delivery of services, payment for services and health care operations. This form complies with the requirements of § 33.13 of the New York State Mental Hygiene Law, federal alcohol and drug record privacy regulations (42 CFR Part 2), and federal law governing privacy of education records (FERPA)(20 USC 1232g). It is not for use for HIV-AIDS related information. Although it includes many of the elements required by 45 CFR 164.508(c), this form is not an "Authorization" under the federal HIPAA rules. An "Authorization" is not required because use and disclosure of protected health information is for purposes of treatment, payment or health care operations. (See 45 CFR 164.506.)

1. I hereby give permission to use and disclose health, mental health, alcohol and drug, and education records as described below.

2. The person whose information may be used or disclosed is:

Youth Name:	**Date of Birth:**

3. The information that may be used or disclosed includes (check all that apply):

   ☐ Mental health records (print or electronic)
   ☐ Alcohol/Drug Records
   ☐ School or Education Records
   ☐ Health records
   ☐ All of the records listed above

4. This information may be disclosed by (see attachment A):

   ☐ Any person or organization that possesses the information to be disclosed
   ☐ The persons or organizations listed in Attachment A
   ☐ The following persons or organizations that provide services to me:

5. This information may be disclosed to (see attachment A):

   ☐ Any person or organization that needs the information to provide service to the person who is the subject of the record, pay for those services, or engage in quality assurance or other health care operations related to that person.
   ☐ The persons or organizations listed in Attachment A
   ☐ The following persons or organizations:

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6. The purposes for which this information may be used and disclosed include:

   - Evaluation of eligibility to participate in a program supported by the Erie County Department of Mental Health;
   - Delivery of services, including care coordination and case management;
   - Payment for services; and
   - Health Care Operations such as quality assurance.

7. I understand that New York and federal law prohibit persons that receive mental health, alcohol or drug abuse, and education records from re-disclosing those records without permission. I also understand that not every organization that may receive a record is required to follow the federal HIPAA rules governing use and disclosure of protected health information. I HEREBY GIVE PERMISSION TO THE PERSONS AND ORGANIZATIONS THAT RECEIVE RECORDS PURSUANT TO THIS AUTHORIZATION TO RE-DISCLOSE THE RECORD AND THE INFORMATION IN THE RECORD TO PERSONS OR ORGANIZATIONS DESCRIBED IN PARAGRAPH 5 FOR THE PURPOSES PERMITTED IN PARAGRAPH 6, BUT FOR NO OTHER PURPOSE.

8 **This permission expires (check applicable box):**

☐ On _____ (date); ☐ Upon the following event: _____

9. This permission is limited as follows:

   ☐ Permission only applies to records for the following time period:

From (date):	**To (date):**

   ☐ Other limitation: _____.

10. I understand that this permission may be revoked. I have received a Notice of Privacy Practices, and understand that if this permission is revoked, it may not be possible to continue to participate in certain programs. I will be informed of that possibility if I wish to revoke this permission. I also understand that records disclosed before this permission is revoked may not be retrieved. Any person or organization that relied on this permission may continue to use or disclose records and protected health information as needed to complete work that began because this permission was given.

I am the person whose records will be used or disclosed. I give permission to use and disclose my records (print and/or electronic) as described in this document.

Signature:	**Date:**

I am the personal representative of the person whose records will be used or disclosed. My relationship to that person is _____. I give permission to use and disclose my records (print and/or electronic) as described in this document.

Print Name:	
Signature:	**Date:**

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Permission to Use and Disclose Confidential Information

Attachment A

(For your records, do not submit to Family Voices Network)

This permission to disclose records applies to the following organizations and people who work at those organizations. These organizations work together to deliver services to residents of Erie County. If your organization submitted a "Referral Form" and "Permission to Use and Disclose Confidential Information" you will receive a notice regarding the status of the submitted application.

	H. Jeffrey Marcus, Attorney At Law
Baker Victory Services	Horizon Health Services
Brylin Hospital(s)	Jewish Family Services
Buffalo Urban League	Kaleida Health
Crisis And Re-Stabilization Emergency Services	Kaleida Health: Children's Psychiatry Outpatient Clinic
Catholic Charities	Kathleen Shannon, LCSW-R
Child & Adolescent Treatment Services	Lisa Gratto, LCSW
Child & Family Services	Mental Health Association
Community Visions, LLC	Mid-Erie Counseling & Treatment Services
Community Connections of NY, Inc.	Monsignor Carr Institute
Compass House Inc.	Native American Community Services
C.O.U.R.T.S. Program	New Directions Youth & Family Services, Inc.
Eating Disorders of WNY Inc.	Paul Lowman, LCSW
Erie County Council for the Prevention of Alcohol and Substance Abuse	People Inc.
Erie County Department of Mental Health	Rasheen Powell, LCSW
Erie County Department of Probation	Robert Hehir, LMSW
Erie County Department of Social Services	Shawn M. Montgomery Community Health Services
Erie County Medical Center	Southwest Keys
Erie County Family Court	Spectrum Human Services
Families' Child Advocacy Network	Summit Educational Resources
Family Help Center	The Family 25, Inc.
Flower Garden Child Care International	Transitional Services, Inc.
Gateway – Longview, Inc.	Tutor Doctor
Heritage Centers	U.B. Department of Family Medicine
Hillside Children's Center	WNY Children's Psychiatric Center