**REQUIREMENTS FOR ALL**

**SERVICE COORDINATION PRESENTATIONS**

|  |  |
| --- | --- |
| Name of youth being presented:  |  |

**The following components are necessary for any Council Inter-Disciplinary Team meetings to go forward. The presenter or Case Manager (CM) from the agency presenting is responsible for ensuring the following are completed prior to the presentation:**

**- Was family invited to the meeting?** **[ ] Yes** **[ ]  No**

**- Was family informed they could bring a support person?** **[ ] Yes** **[ ] No**

 **(If family wants to bring attorney, 24-hour notice is required.)**

**- Was appropriate school official notified of meeting?** **[ ]  Yes** **[ ]  No**

**- Is the family interested in having a Geauga Family First Council Parent Rep attend the meeting as a support?**

 **[ ]  Yes [ ]  No If yes, please contact Brad Welch (440-285-1203 or brad.welch@jfs.ohio.gov)**

**- Did presenter/CM notify appropriate staff and involved agencies?** **[ ] Yes** **[ ] No**

**- Did the family sign Geauga Family First Council’s Release of Information form? [ ] Yes [ ] No**

1. **The common intake form must be filled out in its entirety for all presentations.**

2. **The MULTI-DISCIPLINARY TEAM** meets every Monday at 10:30 am at the Geauga County Board of Mental Health and Recovery Services offices. A case should be presented to the Multi-Disciplinary Team if you seek treatment recommendations for residential placement, therapeutic foster care, or the Geauga Youth Center. Other cases can be presented including those difficult cases for which you may just want some direction or suggestions.

 Requests for placement:

 [ ]  Must include a letter from the child’s current therapist with a recommendation re: level of care

 It is recommended you include other pertinent information to help the Team better understand the child

 and their circumstances, such as:

 [ ]  Social History [ ]  Probation Report

 [ ]  Psychologicals [ ]  School Information

3. **The FAMILY STABILITY TEAM** meets every Thursday at 2:00 p.m. at the Geauga County Board of Mental Health and Recovery Services offices. The Family Stability Team also serves as the Emergency Multi-Disciplinary Team. The Family Stability Team is the entry point for ENGAGE and the BRIDGES Program as well as for shorter-term services, supports, and pro-social activities.

4. **Please encourage the parents and all treatment team members to participate in the planning and presentation of the case.**

5. All opinions regarding the proposed best course of intervention **shall be shared**.

6. Please bring **10 packets** of materials (plus 1 additional packet for each person invited to attend the meeting, ie. school, parent(s), therapists, etc.).

7. A case manager needs to be identified for each case. The case manager is the person who will assume primary responsibility for insuring that services are coordinated and delivered.

|  |
| --- |
| **REASON FOR PRESENTATION**[ ]  ENGAGE [ ]  BRIDGES [ ]  Geauga Youth Center [ ]  Out of county placement [ ]  Pro-social activity [ ]  Other:  |

Referral Time-Line

* + 1. Referral is received from a family member or an agency staff person who is contacted by the next business day by the Case Services Coordinator.
		2. After determining the appropriateness of the referral, the initial Inter-Disciplinary Team meeting is usually scheduled within 5 business days or less.
		3. The case is presented and the recommendations from the Team hearing the presentation are sent to the presenter and other appropriate parties usually within 5 business days.

**SERVICE COORDINATION INTAKE FORM**

**GEAUGA COUNTY FAMILY FIRST COUNCIL**

**12480 RAVENWOOD DRIVE**

**CHARDON, OH 44024**

|  |  |
| --- | --- |
| **Family name:** |       |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date presented:** |       |  | **Presenter:** |       |

|  |  |
| --- | --- |
| **Case Manager:** |       |
| **Referral source:** |

|  |  |
| --- | --- |
| [ ]  Self/Family | [ ]  Juvenile Justice |
| [ ]  Mental Health/BH Provider | [ ]  Child Protective Services |
| [ ]  Education | [ ]  Physical/Hospital |
| [ ]  HMG (E.I. and Home Visiting) | [ ]  WIC Program |
| [ ]  County Board of DD | [ ]  HeadStart/Early HeadStart |
| [ ]  Other :       |

 |

**YOUTH BEING PRESENTED**

|  |  |
| --- | --- |
| **Name:**  |       |
| **DOB:** |       |
| **Age:**  |       |
| **Adopted:** | **[ ]** Yes  **[ ]** No | **In JFS Custody:**  | **[ ]** Yes  **[ ]** No |
| **Sex:** | **[ ]** Male  **[ ]**  Female **[ ]** Transgender |
| **Race:**  |

|  |  |
| --- | --- |
| **[ ]**  American Indian or Alaska Native | **[ ]** White or Caucasian |
| **[ ]**  Asian | **[ ]** Mixed Race |
| **[ ]**  Black or African American | **[ ]**  Other       |
| **[ ]**  Native Hawaiian or Other Pacific Islander | **[ ]** Declined to specify |

 |
| **Mental health diagnosis:**  |       |
| **Current medications:** |       |

**EDUCATION INFORMATION**

|  |  |
| --- | --- |
| **School District of RESPONSIBLITY:** |       |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name of school currently attending:** |  | **On an IEP?** |  | **On a 504?** |  | **Current grade level** |
|       |  | **[ ]** Yes [ ]  No |  | **[ ]** Yes [ ]  No |  |       |

**BACKGROUND INFORMATION**

**Has the youth been assessed via the Ohio CANS?** **[ ]** Yes [ ]  No

If yes: [ ]  Initial [ ]  Follow-up

 If no: has the youth had a risk/safety assessment? **[ ]** Yes [ ]  No Type:

**Is there a Safety/Crisis plan currently in place? [ ]** Yes [ ]  No

**Is there an Individual Family Service Plan (IFSP) currently in place? [ ]** Yes [ ]  No

**Are family team meetings being held regularly? [ ]** Yes [ ]  No

**Are outcomes being measured? [ ]** Yes [ ]  No

|  |
| --- |
| **TREATMENT TEAM MEMBERS:** |
| (JFC Case Worker, Probation Officer, Ravenwood Health Case Worker, Therapist, etc.) |
|       |

**Which of the following agencies are involved with the youth/family at the time of referral:**

|  |  |
| --- | --- |
| [ ]  Board of Developmental Disabilities | [ ]  Child Protective Services |
| [ ]  Juvenile Justice | [ ]  JFS (if receiving services besides Child Protective Services) |
| [ ]  Rehabilitation and Corrections | [ ]  Mental Health/BH Services |
| [ ]  Office for Ohioans with Disabilities | [ ]  Education (any level) |
| [ ]  WIC |  |

**In which of the following areas did the youth/family show significant concerns/needs via the Ohio CANS at the time of intake:**

|  |  |
| --- | --- |
| [ ]  Life Functioning/Independent Living | [ ]  Child Risk Behaviors |
| [ ]  Child Strengths | [ ]  Trauma |
| [ ]  Behavioral/Emotional needs | [ ]  Juvenile Justice Needs |
| [ ]  School/Education | [ ]  Substance Abuse |
| [ ]  Vocational/Employment | [ ]  Developmental Needs |

**If subsequent assessments have been given since the initial presentation, which of the following areas did the youth/family show an increase in strength via the Ohio CANS:**

|  |  |
| --- | --- |
| [ ]  Life Functioning/Independent Living | [ ]  Child Risk Behaviors |
| [ ]  Child Strengths | [ ]  Trauma |
| [ ]  Behavioral/Emotional needs | [ ]  Juvenile Justice Needs |
| [ ]  School/Education | [ ]  Substance Abuse |
| [ ]  Vocational/Employment | [ ]  Developmental Needs |

**HOUSEHOLD INFORMATION**

**ALL household members Age Relationship to Youth**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|       |  |       |  |       |
|       |  |       |  |       |
|       |  |       |  |       |
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|       |  |       |  |       |

|  |  |
| --- | --- |
| **Family address:** |       |
| **Family phone number:** |       |
| **Best time/day to contact:** |       |

|  |
| --- |
| **REASON FOR REFERRAL:**  |
|       |

**BRIDGES**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **If youth is being presented for the BRIDGES Program, please provide the following:**

|  |  |
| --- | --- |
| **Youth’s Social Security Number** |       |
| **Medicaid Number (if applicable)** |       |

**\*Please bring 1 copy of the signed GCJFS Authorized Representative Designation form (re: transportation) to the presentation and give to the Council’s Administrative Assistant.**  |

**FAMILY STABILITY**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **If youth is being presented for the FAMILY STABILITY PROGRAM, please complete the following:**In which of the following areas did the youth/family have needs, whether or not those needs are being addressed:

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  Mental Health | [ ]  Special Education | [ ]  Child Abuse | [ ]  HMG Early Intervention |
| [ ]  Substance Abuse | [ ]  Physical Health | [ ]  Child Neglect | [ ]  Developmental Disabilities |
| [ ]  Poverty | [ ]  Unruly | [ ]  Delinquent | [ ]  Autism Spectrum Disorder |

|  |  |
| --- | --- |
| Activity: |       |
| Start & end date: |       |
| Day(s)/time(s): |       |
| Cost (per session/lesson): |       |
| Family contribution: |       |
| Total cost:  |       |

Does the child have a Primary Care Physician? **[ ]** Yes [ ]  No **VENDOR INFORMATION**

|  |  |
| --- | --- |
| Vendor/Provider: |       |
| Contact person: |       |
| Address: |       |
| Phone number: |       |  | Fax: |       |
| Email address: |       |

 |

|  |
| --- |
| **ANY ADDITIONAL INFORMATION:**  |
|       |

***OPTIONAL***

**FAMILY PAGE**

(As Stated by Family)

**FAMILY STRENGTHS**:

**FAMILY NEEDS/PRIORITIES**:

**FAMILY CULTURAL CONSIDERATIONS**:

**DO YOU HAVE ANY SPECIAL FAMILY TRADITIONS THAT YOUR FAMILY PARTICULARLY LIKES TO DO TOGETHER?**

**FAMILY DREAMS/VISIONS/DESIRES**:

**WOULD YOU LIKE A FAMILY FIRST COUNCIL FAMILY REP TO COME TO THE MEETING AS AN ADVOCATE?** \_\_\_ **YES \_\_\_ NO**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENT SIGNATURE PARENT SIGNATURE**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE DATE**

**Parents are invited to attend the meeting and can bring a support person.**

**GEAUGA COUNTY FAMILY FIRST COUNCIL**

**12480 Ravenwood Dr.**

**Chardon, OH 44024**

**RELEASE OF INFORMATION**

The undersigned, having requested services from the Geauga County Family First Council, do hereby give our consent to the agencies listed below releasing information to the Council for use in preparing and implementing an individual family service plan.

**The family members who are covered by this release are:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | DOB: |  |  |  |  | DOB: |  |
|  |  | DOB: |  |  |  |  | DOB: |  |
|  |  | DOB: |  |  |  |  | DOB: |  |

**The agencies that are authorized to release information are:**

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |
| --- | --- |
|  \_\_\_\_\_\_\_\_\_**INITIAL** | I authorize the agencies and/or individuals specified above to disclose the information I have initialed below to the other treatment team members specified above. It is understood that the information is requested to assist Council staff in planning services with me and/or in completing an assessment of me. (Initial information to be released below.) |

|  |  |  |  |
| --- | --- | --- | --- |
|  Psycho-social History |  Psychological Evaluation |  Psychiatric Evaluation |  Medical Evaluation |
|  Medications Prescribed |  Discharge Summary |  Education/Test Records |  Hospitalization Records |
|  Treatment Notes |  Individual/Family Service Plan |  Lab Reports/X-rays  |  Family First Council Reports |
|  JFS Case Plan |  Probation Reports  |  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

I fully understand that my records are protected under federal and state confidentiality regulations and cannot be released or disclosed without my written permission. I understand the reason(s) the information indicated above is being requested. I fully understand that I may revoke this consent at any time. However, any information shared prior to such a revocation of consent falls within the bounds of this release.

**Initial only one of the following:**

|  |  |
| --- | --- |
| \_\_\_\_\_\_\_\_\_**INITIAL** | This consent, unless revoked earlier, expires on my formal termination from services or ninety (90) days after signing of the Release, whichever occurs first. |
| \_\_\_\_\_\_\_\_\_**INITIAL** | I agree for this Release to be expanded to one hundred eighty (180) days or the end of my involvement with services, whichever occurs first. |

Executed this \_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_

Signatures:

Client: Parent/Guardian (Circle):

Staff Person: Guardian Relationship:

Agency: Witness:

NOTICE TO ALL DRUG AND ALCOHOL CLIENTS: This information has been disclosed to you from records protected by federal confidentiality rules (42CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.