REQUIREMENTS FOR ALL MULTI-DISCIPLINARY
AND SCREENING COMMITTEE PRESENTATIONS

The following components are necessary for any Treatment Team meeting to go forward. The presenter or LCM from an agency is responsible for the following notifications:

- Was family invited to the meeting? ☐Yes ☐ No
- Was family reminded 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
- Did presenter/LCM notify appropriate staff and involved agencies? ☐Yes ☐No

1. The common intake form must be filled out in its entirety.
2. This packet **must** include a letter from the child's current therapist updating the child's status if a therapist is involved. It is recommended, if you are requesting a placement, that you include other pertinent information such as a social history, probation report, psychologicals and school information. If these do not already exist, we do not want you to create them just for the presentation. It is not the Team's desire to create more paperwork but this information will usually be in the file if the child is at a stage where placement outside the home is needed. Brad Welch will review the information you have compiled if you give the packet to him in advance or discuss with you what type of information would be helpful to your presentation.
3. The attached form should be filled out for a presentation to the Multi-Disciplinary Team or Screening Committee
4. The Multi-Disciplinary Team meets on the first Thursday of every month at noon. This meeting usually takes place 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 or for therapeutic foster care. Any case can be presented including those difficult cases for which you may just want some direction or suggestions.
5. The Screening Committee meets every Monday at 11:00 a.m. at the Geauga County Board of Mental Health and Recovery Services offices. The Screening Committee also serves as the Emergency Multi-Disciplinary Team. The Screening Committee is the entry point for all Council-funded programs, which include Bridges and the Therapeutic Youth Center.
   The purpose of the Emergency Multi-Disciplinary Team is to accommodate those cases that need to be presented before the first of the month, i.e. a child in need of an emergency placement.
6. Because, by definition, all children presented for acceptance into Council-funded programs or for case funding have multiple needs, it is likely that a treatment team is already working together on behalf of the child.

Please list all current treatment team members:

_____ _____
_____ _____
_____ _____

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

7. If there are dissenting opinions on the treatment team as to the best course of action, the people holding those opinions <u>should</u> participate in the case presentation. (NOTE: There is nothing wrong with presenting Plan A and Plan B and asking the Multi-Disciplinary Team or Screening Committee to decide and/or give input.)
8. Please bring **8 packets** of materials to the Screening Committee and **10 packets** to the Multi-Disciplinary Team.
9. A lead case manager needs to be identified for each case. The lead case manager is the person who will assume primary responsibility for insuring that services are coordinated and delivered. The lead case manager will follow the Notice Requirements (ORC2151.55-2151.554) for all out-of-county foster home placements. Please contact your agency's representative to the Multi-Disciplinary Team for these requirements.

<u>Referral Time-Line</u>

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 then sent to the presenter, the family (if the family is not the presenter) and to other appropriate parties within 5 business.

Lead Case Manager: _____
Date of receipt of referral: _____

Release Signed: _____

INTAKE FORM
GEAUGA COUNTY FAMILY FIRST COUNCIL
12480 RAVENWOOD DRIVE
CHARDON, OH 44024

FAMILY NAME: _____

DATE PRESENTED: _____ **PRESENTER:** _____

LEAD CASE MANAGER: _____

ALL HOUSEHOLD MEMBERS	**DOB (Age)**		**DOB (Age)**
1. (Father)	( )	**4.**	( )
2. (Mother)	( )	**5.**	( )
3.	( )	**6.**	( )

FAMILY ADDRESS: _____ **FAMILY PHONE:** _____

_____ **BEST TIME/DAY TO CONTACT:** _____

PRIMARY SOURCES OF FINANCIAL SUPPORT FOR FAMILY: FOR PARENTS/GUARDIANS: IF EMPLOYED, PLEASE LIST THE FOLLOWING INFORMATION ABOUT EMPLOYER:

☐ **EMPLOYMENT**	☐ **UNEMPLOYMENT COMP**	**NAME:** _____
☐ **SOCIAL SECURITY**	☐ **WORKMENS COMP.**	**PHONE:** _____
☐ **S.S.D.**	☐ **CHILD SUPPORT**	**NAME:** _____
☐ **S.S.I.**	☐ **ALIMONY**	**PHONE:** _____
☐ **OWF (ADC)**	☐ **PENSION**	
☐ **G.A.**		

INSURANCE INFORMATION (COMPLETE OR ATTACH COPY OF CARD)

MEDICAL INSURANCE: _____ **MEDICAID NUMBER:** _____

NAME OF COMPANY: _____ **MEDICAID NUMBER:** _____

NAMES OF INSURED: _____

POLICY NUMBER: _____

POLICY EFFECTIVE DATE: _____

For office use only:
Case accepted for service coordination: __*YES* / __*NO* *Referred to Council for funding:* _____

REASON FOR REFERRAL:

MEDICAL INFORMATION:

DATE OF LAST PHYSICAL:

EXISTING MEDICAL INFORMATION:

CURRENT MEDICATION:

MENTAL HEALTH DIAGNOSIS (if available)**:**

FAMILY HISTORY:

FAMILY INTERACTION PATTERNS:

EDUCATION INFORMATION OF CHILDREN IN HOME:
HOME SCHOOL DISTRICT: _____

STUDENTS NAME	NAME OF SCHOOL	CITY/STATE	ON IEP?	GRADE

FORMAL SUPPORTS

Agencies Involved (Please check all appropriate responses):

- ☐ **Geauga County Board of DD**
- ☐ **Geauga County Dept. Human Services**
- ☐ **Geauga County Health Dept.**
- ☐ **Geauga County Juvenile Court**
- ☐ **Catholic Charities**
- ☐ **Social Security Administration**
- ☐ **Geauga County Public Schools**
- ☐ **Geauga County After School Program**
- ☐ **Ohio Dept. of Youth Services**
- ☐ **BVR**
- ☐ **Ravenwood**
- ☐ **OTHER:**

Please fill in details below:

AGENCY	MOST RECENT CONTACT DATE	CONTACT PERSON	PHONE	MISC. INFO.

INFORMAL SUPPORTS

Relatives, Friends, 4-H Club, Church Affiliation, Scouts, Support Groups, Organizations:

ORGANIZA-TION NAME	NATURE OF RELATION-SHIP	MOST RECENT CONTACT PERSON	CONTACT PERSON	PHONE	MISC. INFO.

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:

RELEASE OF INFORMATION FORM SIGNED? ___ 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:

1. _____ DOB:_____
2. _____ DOB:_____
3. _____ DOB:_____
4. _____ DOB:_____
5. _____ DOB:_____
6. _____ DOB:_____

The agencies that are authorized to release information are:

l._____

2._____

3._____

4._____

5._____

6._____

_____
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 staff of the program in planning services with me and/or in completing an assessment of me. (Initial information to be released.)

___Psycho-social History	___Psychological Evaluation	___Psychiatric Evaluation
___Medical Evaluation	___Medications Prescribed	___Discharge Summary
___Education/Test Rec.	___Hospitalization Records	___Treatment Notes
___Ind./Family Ser. Plan	___Lab Rpts./X-rays	___Family First Council Rpts.
___DHS Case Plan	___Probation Reports	___Other (specify_____)

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.

GEAUGA COUNTY FAMILY COUNCIL
12480 Ravenwood Dr.
Chardon, OH 44024

RELEASE OF INFORMATION

Initial only one of the following:

_____ This consent, unless revoked earlier, expires on my formal termination from services or ninety (90) days after signing of the Release, whichever occurs first.

_____ 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): _____

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.