



REFERRAL PROCEDURE CHECKLIST FOR CASSP I REVIEW

- ☐ Child/Adolescent meets criteria for CASSP Level I review

ELIGIBILITY CRITERIA – must meet numbers 1 and 2 plus number 3, 4 or 5.

- ☐ 1. Birth to 18 years of age *(to age 21 if receiving Special Education services)*.
- ☐ 2. Significantly diminished functioning in physical, cognitive, emotional, behavioral, or social areas.
- ☐ 3. Receiving services from two or more child-serving agencies, each having difficulty serving/managing care. The individual's school will be considered as one of the child serving agencies only if the person is experiencing significant difficulties in the school setting.
- ☐ 4. Out of home placement is anticipated or recommended: *(Specify)*
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- ☐ 5. Pending discharge or transfer from an out-of-home placement: *(Specify)*
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- ☐ Referring worker explained the purpose of a CASSP review to the custodial parent, grandparent, or guardian, and at least one parent or guardian agrees to attend/participate in the CASSP meeting.
- ☐ Custodial parent, grandparent, or guardian signed the CASSP release of information form.
- ☐ Adolescent 14 years of age or older signed CASSP release of information form.
- ☐ Referring worker attached most recent evaluations and/or reports.
- ☐ Referring worker completed referral form and mailing list.
- ☐ Referring worker reviewed referral with agency supervisor or core team representative.

OR

- ☐ Referral sources with school districts, intermediate unit and other agencies discussed referral with CASSP Coordinator prior to submitting referral.
- ☐ Referring worker submitted referral packet to the CASSP Coordinator.
- ☐ Referring worker notified custodial parent, grandparent, or guardian of the date and time of the CASSP meeting and confirmed their willingness/ability to attend.

CORE PRINCIPLES: Child and Adolescent Service System Program (CASSP)

Pennsylvania's Child and Adolescent Service System Program (CASSP) is based on a well-defined set of principles for mental health services for children and adolescents with or at risk of developing severe emotional disorders and their families. These principles, variously expressed since the beginning of CASSP, can be summarized in six core statements. When services are developed and delivered according to the following principles, it is expected that they will operate simultaneously and not in isolation from each other.

1. Child-centered

Services are planned to meet the individual needs of the child, rather than to fit the child into an existing service. Services consider the child's family and community contexts, are developmentally appropriate and child-specific, and also build on the strengths of the child and family to meet the mental health, social and physical needs of the child.

2. Family-focused

Services recognize that the family is the primary support system for the child. The family participates as a full partner in all stages of the decision-making and treatment planning process, including implementation, monitoring and evaluation. A family may include biological, adoptive and foster parents, siblings, grandparents and other relatives, and other adults who are committed to the child. The development of mental health policy at state and local levels includes family representation.

3. Community-based

Whenever possible, services are delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community. Community resources include not only mental health professionals and provider agencies, but also social, religious and cultural organizations and other natural community support networks.

4. Multi-system

Services are planned in collaboration with all the child-serving systems involved in the child's life. Representatives from all these systems and the family collaborate to define the goals for the child, develop a service plan, develop the necessary resources to implement the plan, provide appropriate support to the child and family, and evaluate progress.

5. Culturally competent

Culture determines our world view and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particular group of people.

Note: Pennsylvania's cultural competence initiative has focused specifically on African Americans, Latinos, Asian Americans and Native Americans who have historically not received culturally appropriate services.

6. Least restrictive/least intrusive

Services take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive available to meet the needs of the child and family.

**CHILD AND ADOLESCENT SERVICE SYSTEM
 PROGRAM (CASSP)
 CUMBERLAND / PERRY COUNTIES**
Referral Form for Level I Review

I. Consumer Information:

S.S. # _____ - _____ - _____

Consumer Name _____

Age _____

Gender _____

D.O.B. _____

Address _____

County of Residence _____

Township _____

School _____

School District _____

Grade _____

Has child been referred for a Special Education process? ☐ Yes ☐ No

Check any Special Education Services provided: ☐ ES: Itinerant Classroom ☐ LS: Itinerant Classroom ☐ 1:1 Aide

Check the box below and provide a contact person if the child is or has been involved with either agency.

☐ CYS Contact: _____ ☐ JPO Contact: _____

Circumstances/conditions leading to CASSP referral: _____

What previous mental health services have been tried? (*List below*)

<u>Type of Service</u>	<u>Provider</u>	<u>Dates</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What are the consumer's strengths? _____

II. Family Information:

What are the family's strengths? _____

Who does the consumer live with? (*List members of household below*)

<u>Name</u>	<u>Relationship</u>	<u>Age</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who has legal custody of the consumer?

☐ Parents share custody ☐ Mother ☐ Father ☐ Children & Youth Services

☐ Other (*specify*): _____

What significant people or community organizations other than agencies (i.e. natural supports) are being utilized to support this consumer?

Social and Family History: _____

Are there significant family/cultural issues of which the team should be aware? _____

III. Physical and Behavioral/Mental Health Information:

Specialists:

Primary Care Physician _____

Psychiatrist _____

DSM IV Multi-axial Diagnoses:

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

Other (*specify*) _____

Evaluated By:

Evaluator _____

Date of Evaluation _____

Facility _____

Address _____

Phone _____

Medications:

Dosage:

Prescribing Physician:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Type of Insurance Coverage:

☐ BC/BS _____

☐ HMO _____

☐ Medical Assistance:

Status: ☐ Current ☐ Applied or pending MA#: _____

☐ Other (*specify*): _____

Other information which the referring agency believes to be relevant includes: _____

Referring Worker _____ Phone _____ Date _____

Prior review by agency core team member _____

CUMBERLAND/PERRY CASSP – Level I

Mailing List

Referring Worker: Please list all individuals who should be invited to a review for referred consumer. Please be sure that listed individuals or agencies are included on the signed release of information.

Date

Consumer Name

Age

Address

Phone

☐ Perry County Core Team ☐ Cumberland County Core Team

Type of Relationship:

☐ Custodial ☐ Foster

Parent(s) Name

Address *(if different from above)*

Phone

email

Type of Relationship:

☐ Custodial ☐ Foster

Additional Parent(s) Name *(if applicable)*

Address *(if different from above)*

Phone

email

School and/or Intermediate Unit Information:

Primary Contact Name

Contact Title

School Building

School District

Address

City

State

Zip

Other School or IU Personnel:

Name:

Title:

Phone:

email:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other Involved Agencies: (C&Y Services, Mental Health, Mental Retardation, Drug & Alcohol, Juvenile Probation, etc.)

Referring Worker		Relationship / Title	
Agency	Phone	email	
Address	City	State	Zip

Primary Contact		Relationship / Title	
Agency	Phone	email	
Address	City	State	Zip

Primary Contact		Relationship / Title	
Agency	Phone	email	
Address	City	State	Zip

Primary Contact		Relationship / Title	
Agency	Phone	email	
Address	City	State	Zip

Primary Contact		Relationship / Title	
Agency	Phone	email	
Address	City	State	Zip

The following individuals are significantly involved with this child and could be included to the child's benefit in service planning: *(be sure to include on signed release).*

Name	Relationship	Phone	
Agency		email	
Address	City	State	Zip

Comments: _____

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Consumer

Date of Birth

Parent(s) or Guardian

I hereby authorize the following agencies or individuals to participate in the CASSP meeting:

School District (*specify*):

Alternative School:

Other Agencies (*out patient providers, psychiatrist, JPO, etc*):

Other Supports (*family, friends, relatives, mentors, etc*):

☐ Perry County Core Team

☐ Cumberland County Core Team

I also authorize the disclosure of the following documents or reports relevant to the named individual above:

☐ Psychological Evaluations

☐ Psychiatric Evaluations

☐ Social History

☐ Treatment Plans

☐ Progress Reports

☐ School Records

☐ Family Service Plans

☐ Medical Records

☐ Other

☐ Vocational Evaluations

☐ Behavior Modification Plans

Please note the CASSP Core Team consists of the following professionals: Capital Area IU, Cumberland/Perry County CYS, Cumberland/Perry County JPO, Holy Spirit, Cumberland County Aging, Cumberland/Perry County D&A, Cumberland/Perry County MH/MR, Stevens Center, CBHNP, and Perry Human Services. Information at the CASSP meeting will be held in strict confidence and used for the purpose of assessment of needs, planning and coordination of services, and evaluation of progress and effectiveness of services. The CASSP Core Team will not disclose any information to any agency or service provider and all materials gathered at the CASSP meeting will be collected at the end of the meeting and shredded. The CASSP Coordinator will assist with treatment teams & families identified in the aftercare service plan.

This authorization will expire in one year subsequent to the date of signature, unless revoked by a written request of the consumer (if over the age of 14) or consumer's parents or legal Guardian.

Signature of Consumer if 14 or older

Begin Date

End Date

Signature of Parent or Guardian

Begin Date

End Date

Witness

Begin Date

End Date

Verbal Consent: We, the undersigned, certify that the above named consumer and legal guardians understand the nature and provision of this authorization and has freely given his/her verbal consent in lieu of signature.

Signature of Witness

Title

Begin Date

End Date

Signature of Witness

Title

Begin Date

End Date