Tompkins County Solutions for Youth and Families/ SPOA Referral Form

(Please Fax to Tompkins County Mental Health at 607-274-6316, or send to Leslie Connors at 201 East Green St. Ithaca, NY 14850)

Person making referral:	Date of Referral:
Title: Agency Name and address:	Agency Phone: *e-mail address:
(*If the Referral is for Care Management and the child is currently in Foster Care, the Local Dept. of Social Services must complete the referral)	

Youth's First Name:	Middle Initial:	Last Name:
DOB:	Gender: ___M ___F ___Other	County of Residence:
Race: __African/American __Asian/Pacific Islander __Biracial __Caucasian __Hispanic __Native American __Other:		
Medicaid CIN #:	Medicaid Managed Care Organization Name:	
Does Youth Receive Benefits/Financial Support Independent of Parent's Income? __Yes __No		
Indicate any need for language/interpretation services; specify language spoken if other than English:		

1. Caregiver Information

Parent/Caregiver (First, Last):	Primary contact: __Yes __No
Address:	Phone:
E-mail Address:	
Parent/Caregiver (First, Last):	Primary contact: __Yes __No
Address: (if different)	Phone:
*E-mail Address:	
Is the youth's parent/guardian currently enrolled in the Health Home Program? __Yes __No	
Are the parents legal guardians? __Yes __No (if no, please list person/agency below.	
Legal Guardian:	Relationship to youth:
Address:	Phone:
*E-mail Address:	

* e-mail use for scheduling purposes only, not for sharing confidential information

2. Household Composition (Please include relatives and non-relatives currently living in the home)

Name	Relationship to Youth	Approximate Age

3. Strengths and Resources

Please describe important strengths, resources, and things that have worked for this youth and the family. This can include extended family members, important adults, community organizations, faith communities, and other services that families have found to be helpful.

Please fill out with youth:	
Favorite Activities	
Favorite School Subjects	
Hobbies, talents, skills, & abilities	
Favorite people	
Favorite place	
Areas where I can help others	
Career or job interests	
Interesting things I have done	
A special experience	
Something I have overcome	
Other important information about me	

4. Background Overview and Concerns

Please give a brief overview, including significant recent events, issues, and concerns.

Please indicate things that have been helpful in addressing concerns.

What are some of the obstacles that interfere with success?

5. Services and Resources Requested

Please describe what services/resources you are seeking and what you envision those services doing. If unclear about resources, please contact SPOA Coordinator (607-597-0992):

- ☐ Care Management (*Complete Appendix A.1 and A.2; Appendix B.1 and B.2 may also need to be completed – call SPOA Coordinator with questions*)
  Preference if known: ___Elmira Psychiatric Center ___ Franziska Racker Centers

- ☐ Waiver Services
- ☐ Community Residence
- ☐ Residential Treatment Facility
- ☐ Other- please describe:_____

How will you know that the services recommended were successful for the youth and family?

6. Mental Health Diagnostic Information (DSM V)

Primary Diagnosis	Code	Narrative, if needed.
☐		
☐		
Who made this diagnosis:		Date of diagnosis:

7. Mental Health Treatment and Service History

Current therapist:	Agency:	Phone:
Length/dates of treatment (approx):		

Other Past or Current services ("x"):

__**P** __**C** Intensive Case Management (ICM/EPC)
__**P** __**C** Intensive Case Management (Tomp. County)
__**P** __**C** WAIVER service coordination
__**P** __**C** Dispositional Alternatives (DAP)
__**P** __**C** County Clinic Treatment
__**P** __**C** Private therapy/ private agency
__**P** __**C** Crisis response services
__**P** __**C** Day Treatment
__**P** __**C** Respite
__**P** __**C** Medication management
__**P** __**C** Vocational training
__**P** __**C** Independent Living skills
__**P** __**C** Substance abuse treatment
__**P** __**C** Alcohol abuse treatment
__**P** __**C** Family Support Services

__**P** __**C** Mental Health Association
__**P** __**C** Transportation
__**P** __**C** After school/weekend programs
__**P** __**C** Specialized summer programs
__**P** __**C** Special education programs
__**P** __**C** Speech and language therapy
__**P** __**C** Mentoring
__**P** __**C** Therapeutic Foster care (e.g.: REACH)
__**P** __**C** Residential treatment facility (RTF)
__**P** __**C** Residential treatment Center (RTC)
__**P** __**C** Community residence/group home
__**P** __**C** OPWDD Center
__**P** __**C** Wilderness/Outward Bound
__**P** __**C** Private residential school
__**P** __**C** Other (please list)

__**P** __**C** Inpatient State Hosp.*
__**P** __**C** Inpatient Private Hosp.*
*If current, name of facility and expected date of discharge:_____
_____
_____

__**P** __**C** DSS Preventive Services
__**P** __**C** DSS Foster care
If youth is currently receiving preventive services, list name of provider:_____
_____

Has this youth ever lived away from their family? If so, where, with whom, and for how long?

Hospitalization History: Please list any Emergency Room or Psychiatric admissions. Please include place and approximate admission/discharge dates if known.

Current Medications:	Prescriber:

8. Education

School Name/District:	
Current Grade:	CSE Classification (if applicable):

Description of School Placement (check all that apply):
__Regular Class in age appropriate grade
__Regular class, above grade level
__Regular class, but behind at least one grade
__Special Education evaluation initiated/in process
__Response to intervention/RTI
__504 plan
__Special Ed, primarily mainstreamed
__Special Ed in 8 or 6:1:1 classroom
__Day Treatment
__Residential program outside district

__BOCES
__Vocational training only
__Part-time vocational/educational
__GED program
__Home instruction
__Private school (Name):
__High School Graduate
__GED graduate
__College(Name):
__Not enrolled in school
__Unknown

School Contact Person(s) (title):	Phone:

Who does youth identify as trusted adult in school setting?

Additional School Information/contacts:

9. Legal Status

Custody: __Biological Parent(s): Mother, Father, or Both (please circle) __Adoptive Parent(s): Mother, Father, or Both (please circle) __Grandparent(s)	__Other family members __Local DSS __Emancipated Minor __Other (specify)
Youth's legal status: __PINS Diversion __PINS __Juvenile delinquent __Juvenile Delinquent-restricted	__Juvenile Offender __Drug Court __None __Other: __Unknown

10. Additional Comments/Information **(please include people that might want to participate in the Solutions for Youth and Families/SPOA meeting to help support the youth and family. Use back if necessary.)**

How would you rate the ease of filling out this form? ___very easy ___easy ___average ___hard ___very hard

Please share any suggestions you might have for improving this form or the referral process

Tompkins County Solutions for Youth and Families (includes SPOA)

Part 1: Consent to Release Confidential Information

Client Name:_______________________________________ Date of Birth:_____________________________

My signature below authorizes consent for the Tompkins County Solutions for Youth and Families Team (includes SPOA Team) to disclose and receive information regarding a request for services. Team members include representatives from the following services:

School District____________________________________

Mental Health Association of Tompkins County | Tompkins County Probation Department | Elmira Psychiatric Center-Care Management

Franziska Racker Centers -Care Management | Pathways Home and Community Waiver | Catholic Charities

Family & Children's Service | Tompkins County Mental Health Services –-Clinic | SPOA Young Adult Representative and Parent Partner

Tompkins County Department of Social Services/Preventive, CPS and Foster Care | Cayuga Medical Center

Other:____ Other:____

It is understood that this information will be used to evaluate (youth's name)______________________________ for possible connection with HCBS Waiver, Care Management, Family Based Treatment or placement in community residence or residential treatment. With my permission, my child may receive services from one of the above.

The following information may be shared:

- ✓ SPOA referral, referral source, reason for referral
- ✓ SPOA intake/assessment including household information, presenting concerns, diagnosis, medication, current/past services, education information
- ✓ Services requested

The information is needed:

- ✓ To provide ongoing communication with the referring agency
- ✓ To provide ongoing treatment/services
- ✓ To coordinate treatment efforts with the family and SPOA team
- ✓ For tracking and follow up to ensure quality service delivery.

Your participation in the meeting is vital to your child's service planning!

I understand that I can revoke this authorization in writing at any time. Unless revoked, this authorization **will expire one year** from the signature date. I understand a copy of the referral will be given to the assigned service providers. Treatment records from NYS Office of Mental Health may not be re-disclosed without my written consent.

____ Relationship to Client: _________________________

Signature of Parent/ Guardian Date

____

Signature of Witness Date

::

Part 2: Revocation of Consent to Release Confidential Information: I hereby revoke my authorization to use/disclose information indicated in Part 1, to the person, organization, facility or program whose name is listed in Part 1 of this Consent.

Signature of Parent/ Guardian:____ Date:_______________________

Health Home Care Management Services Eligibility Requirements:

1. Youth meets the NYS DOH eligibility criteria of (refer to Eligibility Category Information sheet):

☐ a. **Two or more chronic conditions**
OR

☐ b. **HIV/AIDS**
OR

☐ c. **Serious Emotional Disturbance**: SED is defined as a child or adolescent (under the age of 21) that has a designated mental illness diagnosis in the following DSM categories (Schizophrenia Spectrum and other psychotic disorders; bipolar and related disorders; depressive disorders; anxiety disorders; obsessive-compulsive and related disorders; trauma and stressor-related disorders; dissociative disorders; somatic symptom and related disorders; feeding and eating disorders; gender dysphoria; disruptive, impulse-control, and conduct disorders; personality disorders; paraphilic disorders) as defined by the most recent version of the DSM of Mental Health Disorders **AND** has experiences the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis:

__Ability to care for self (e.g. personal hygiene; obtaining and eating food; dressing; avoiding injuries); **OR**

__Family life (e.g. capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); **OR**

__Social relationships (e.g. establishing and maintaining friendship; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); **OR**

__Self-direction /self-control (e.g. ability to sustain focused attention for a long enough period of time to permit completion of age appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability; **OR**

__Ability to learn (e.g. school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).

OR

☐ d. **Complex Trauma** (do not complete if there is a qualifying diagnosis)
Note- If this is the only box checked on the form you must ALSO complete the Complex Trauma Referral Cover Sheet and the Complex Trauma Exposure Screen and attach with the referral form.

Definition of Complex Trauma:

1.. The term complex trauma incorporates at least:
   a. Infants/children/or adolescents' exposure multiple traumatic events, often of an invasive, interpersonal nature, and
   b. The wide-ranging, long-term impact of this exposure.
2. The nature of the traumatic events:
   a. Often is severe and pervasive, such as abuse or profound neglect;
   b. Usually begins early in life;
   c. Can be disruptive of the child's development and the formation of a healthy sense of self (with self-regulatory, executive functioning, self-perceptions, etc.);
   d. Often occur in the context of the child's relationship with a caregiver; and
   e. Can interfere with the child's ability to form a secure attachment bond, which is considered a prerequisite for healthy social-emotional functioning.
3. Many aspects of a child's healthy physical and mental development rely on this secure attachment, a primary source of safety and stability.
4. Wide-ranging, long-term adverse effects can include impairments in:
   a. Physiological responses and related neurodevelopment,
   b. Emotional responses,
   c. Cognitive processes including the ability to think, learn, and concentrate,
   d. Impulse control and other self-regulating behavior,
   e. Self-image, and
   f. Relationships with others.

AND

2. Youth has significant behavioral, medical or social risk factors which can be addressed through care management.

Check all that apply and explain how youth exhibits risk factors:

Risk Factors:	Explanation of how exhibited:
☐ At risk for adverse event (death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement) ☐ Has inadequate social/family/ housing support, or serious disruptions in family relationships; ☐ Has inadequate connectivity with healthcare system; ☐ Does not adhere to treatments or has difficulty managing medications; ☐ Has recently been released from incarceration, placement, detention, or psychiatric hospitalization; ☐ Has deficits in activities of daily living, learning or cognition issues; **or** ☐ Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home.	

New York State Department of Health

Appendix B.1

Complex Trauma Referral Cover Sheet

Referral of a Child/Youth with Complex Trauma as a Single Qualifying Condition in Order to Establish Eligibility for Health Home.

Required Information

Child's Name: DOB: Child's Current Address: Medicaid #:	**Referral Source Name:** Relationship: Agency (if appropriate): Address: Phone:
Parent/Guardian Name: Address: Phone:	**Medical Consent (if different):** Name: Address: Phone:

Date of Referral:

Complex Trauma Exposure Screening Form (attach screen)

Completed By:

Date of Screening:

Reason for Referral (Brief narrative, please include any details on events, behaviors, etc. that prompted the referral):

_____

_____

_____

_____

_____

Optional/Desired Information

Completion of this cover sheet and the complex trauma exposure screen is sufficient for referral.
Providing the following information may facilitate timeliness of the referral.

Last School Attended Name: Address: Contact Person:	**Behavioral Health** Provider Name: Address/Phone: Contract Person:
Foster Care/DCYF County/Agency Name: Address/Phone: Contact Person:	**Other Collateral** Provider Name: Address/Phone: Contact Person:
Primary Care/Pediatrician Name: Address/Phone:	**Attached Documentation** __Psychiatric __Psychological __Medical/Physical __School Information: __Other:

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Appendix B.2

Complex Trauma Exposure Screen (CTES)

Please indicate whether the child experienced the following types of traumatic events using all available information (e.g. self or caregiver report, review of records, etc.). Conduct a **brief** interview with the child *only if you do not already have enough information to make a determination about complex trauma exposure*. To avoid undue distress, ask only about types for which you do not already have information. If information for a particular trauma is known, *do not request additional details from the child for that type.* For example, if the child has a documented history of physical neglect, endorse "y," and move on to the next category. *Once the presence of 2 or more trauma types has been reported (or 1 lasting greater than 6 months), discontinue the interview portion of the assessment.*

Sources of Information (check all that apply):

[ ] Parents/Caregiver [ ] Chart/Records Review [ ] Child/Youth Report [ ] Other (specify):

Prompts/Questions (suggested prompts/questions for assessing trauma exposure within each category)	**Trauma Type**	**Present? Y/N**	**>6 mos?**
Was there a time when adults who were supposed to be taking care of you didn't? Has there ever been a time when you did not have enough food to eat? Did a parent or other adult in the household often…. Swear at you, insult you, put you down, or humiliate you? Or act in a way that made you afraid that you might be physically hurt?	**Physical/Emotional Neglect** or **Emotional Maltreatment**		
Have you lived with someone other than your parents/caregiver while you were growing up (because they couldn't take care of you or you were kicked out)? Have you ever been homeless? This means you ran away or were kicked out and lived on the street for more than a few days? Or you and your family had no place to stay and lived on the street, or in a car, or in a shelter?	**Displacement**		
Have you lost a primary caregiver through death, incarceration, deportation, migration, or for other reasons? Have you been left in the care of different people due to parental incapacity or dysfunction, even if your primary place of residence did not change? Have you had two or more changes in your primary caregiver or guardian, either formally (legally) or informally?	**Attachment Disruption**		
Has anyone ever made you do sexual things you didn't want to do, like touch you, make you touch them, or try to have any kind of sex with you? Has anyone ever *tried* to make you do sexual things you didn't want to do? Has anyone ever forced you (or tried to force you) to have intercourse?	**Sexual Abuse** **Sexual Assault/Rape**		
Have you ever been hit or intentionally hurt by a family member? If yes, did you have bruises, marks or injuries?	**Physical Abuse**		
Have you ever *seen* or *heard* someone in your family/house being beaten up or have you ever *seen* or *heard* someone in your family/house get threatened with harm?	**Domestic Violence**		
Have you ever *seen* or *heard* someone being beaten, or who was badly hurt? Have you seen someone who was dead or dying, or *watched* or *heard* them being killed? Has anyone ever hit you or beaten you up (physically assaulted you)? Has anyone ever threatened to physically assault you (with or without a weapon)?	**Community Violence (chronic)** or **Interpersonal Violence (episodic)**		
Did other children often tease or insult you, put you down, or threaten you physically? Did they spread lies about you or turn people against you?	**Bullying**		
Have you or anyone in your family been involved in, or *in direct danger* from a terrorist attack, war, or political violence?	**Terrorism/War/ Political Violence**		
Has anyone ever stalked you? Did anyone ever try to kidnap you?	**Stalking/ Kidnapping**		
Is there anything else really scary or very upsetting that has happened to you that I haven't asked you about? Sometimes people have something in mind but they're not comfortable talking about the details. Is that true for you?	**Other Trauma**		
Number of different types of traumas experienced (total # Trauma Types = Yes)			
Number of chronic traumas experienced (total # Trauma Types Experienced for more than 6 months).			

If number of Trauma Types = 2 or greater →→→→ Refer child to Health Home for Further Assessment.

If 1 Trauma Type lasting > 6 months (i.e. chronic) →→→→ Refer child to Health Home for Further Assessment.

***Prompts derived from Trauma History Checklist & Interview**