CHAMPAIGN COUNTY
FAMILY & CHILDREN FIRST COUNCIL

INFORMAL
Child & Family Team Referral Form

Stephanie Newland, Program Coordinator

Address: 2200 S. US Hwy. 68, Urbana OH 43078 **Phone**: 937.653.4490 x 222
Email: stephanie.newland@mccesc.org **Fax**: 937.652.2648

DATE OF REFERRAL:	Name of person making referral: _____ Agency/Relationship to child: _____ Agency Address: _____ _____ Phone Number:_____

Youth Name: _____ Date of Birth:_____

Gender: ____ Male ____ Female ~~Social Security #:~~_____

Parent/Guardian: _____ Race: _____

Address: _____

Phone: _____ Secondary Phone #: _____

Marital Status: _____ Family Size: _____

Adjusted Gross Mo. Income: _____ Mental Health Diagnosis: _____

School of Residence/Attendance: _____

Checklist for Funding or Service Request

Completed	Required documentation to be submitted to the FCFC
	Proof of service coordination (minutes/notes from interagency team meeting with signature verifying the parent/youth were present).
	Consent for Release of Information
	Funding/Service Request Form
	Copy of At-risk Rating Screening Tool

Family and Children First Council Use Only

Date referral received: _____ **Received by:** _____

☐ **Accepted** ☐ **Denied** **Date family notified of status:**_____

IF DENIED, WHAT RESOURCES/RECOMMENDATIONS WERE PROVIDED?

CHAMPAIGN COUNTY
FAMILY & CHILDREN FIRST COUNCIL

CHAMPAIGN COUNTY FAMILY & CHILDREN FIRST COUNCIL
INTERSYSTEM CHILD & FAMILY TEAM
UNIVERSAL RELEASE OF CONFIDENTIAL INFORMATION

Name of Youth: _____ Date of Birth: _____

As parent or legal guardian, I authorize the following **initialed** agencies to obtain and release information regarding _____. **(Please DO NOT use check marks. Parent/Guardian must put initials.)**

*_____ Logan-Champaign Counties Mental Health, Drug and Alcohol Services Board
*_____ Champaign Co. Family and Children First/CFT/Diversion Team
*_____ Madison-Champaign ESC
_____ Board of Education (District of Residence/Attendance): _____
_____ Mac-A-Cheek Learning Center
_____ Champaign Co. Board of Developmental Disabilities
_____ Champaign Co. Department of Health, including WIC/BCMH
_____ Champaign Co. Department of Job & Family Services, including Children Protective Services
_____ Champaign Co. Domestic Relations-Juvenile-Probate Court
_____ Champaign Co. Early Intervention
_____ Nationwide Children's Hospital
_____ Dayton Children's Hospital
_____ Consolidated Care, Inc.
_____ Urbana Family Medicine & Pediatrics
_____ Oesterlan Services for Youth, Inc.
_____ Well Spring
_____ Parent Mentor: Jacqueline Howley
_____ Other: _____
_____ Other: _____

_____ Adriel
_____ Choices
_____ Respite Connections
_____ Residential Administrators
_____ Caring Kitchen
_____ Parent Advocate (PAC)
_____ Other: _____
_____ Other: _____
_____ Other: _____

The agencies **initialed** above may share with each other, the following information in order to develop a service plan for the above named youth.

*_____ Medical Records
*_____ Children's Protective Services Information
*_____ Scholastic/Attendance Records
*_____ Psychological Reports

*_____ Psychotherapy Records
*_____ Verbal Exchange of Information
*_____ _____
*_____ _____

I further understand that these records are protected by state and federal confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time.
This consent expires automatically 180 days from the date signed.

Signed this _____ Day of _____, 2_____

Signature of Parent or Guardian: _____

Witness: _____

Revoked/date: _____ Signature: _____

Witness: _____

IF YOU RECEIVE INFORMATION RELEASED WITH THIS FORM THE FOLLOWING FEDERAL LAW APPLIES TO YOU: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR, Part2), 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 42 CFR, Part 2. A general authorization is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse consumer.

Funding Request Form
Champaign County Family and Children First Council
Intersystem Services Agreement

Youth Name: Youth DOB:

Parent Name: Date of Request:

Who is Primary Physician:

Request Submitted by:

Agency Submitting:

Type of Child Family Team (CFT):

☐ Formal CFT–Wrap-A-Round ☐ Informal CFT

Identified Unmet Need by CFT (justification of need)**:**

Description of Service/Placement to be delivered and tie to treatment goals:
(dates, times, costs, etc.)**:**

List other services/ Resources exhausted:

Agreed Upon Term of Service/Placement ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other
Is Youth Medicaid Eligible: ☐ Yes ☐ No
Is Youth Covered by Insurance ☐ Yes ☐ No

Estimated cost of Service: $_____

Vendor Payment/ purchase information (if requesting funding and not service)**:**

Name:

Address:

Phone #: **Email:**

Family and Children First Council Use Only	
Fund to be utilized:	☐ SOC-FCSS ☐ Pooled Funds ☐ Other:
Service Requested:	☐ Parent Coaching ☐ Youth Mentoring ☐ Respite ☐ Gas Voucher ☐ Family Supportive Services* ☐ Other:

*Family Support may include family/ youth incentives/ rewards, behavior modification supplies, enrichment/bonding activities, etc.

Diversion Team Agency Contact Name:

Agency Director Approval: **Date:**

Champaign County Family & Children First Council
At-Risk Screening Tool

Youth Name: _____ Date of Birth: _____

Current Youth Agency Involvement

What agencies are currently involved with the family? Please check all that apply:	Name of Agency	Contact Person	Phone Number
☐ Mental Health:			
☐ Alcohol/Drug Treatment:			
☐ Caring Kitchen			
☐ Champaign Co. Children's Protective Services			
☐ Champaign Co. Health District			
☐ Champaign Co. Help Me Grow			
☐ Champaign Co. Job and Family Services			
☐ Champaign Co. Domestic Relations-Juvenile-Probate Court			
☐ Champaign Co. Board of Developmental Disabilities			
☐ Champaign Co. Residential Services			
☐ WIC			
☐ Other:			

Know Presenting Risks to Child/Youth:
within the last 3 months

☐ **Suicidal Ideation, Gestures, Attempts (3 pts)**	☐ **Violent Behavior (toward others/animals/property)3pts**	☐ **Chargeable for Sex Offense (3 pts)**
☐ Self-Injurious Behavior (2 pts)	☐ Hears voices/Sees things (2 pts)	☐ Fire Setting – Current or History (2 pts)
☐ Acute Family Crisis (2 pts)	☐ Victim of Physical, Emotional or Sexual Abuse (2 pts)	☐ Verbal/Written Threats to Others (2 pts)
☐ Runaway – Current or History (2 pts)	☐ Youth/Family's Lack of Stable residence/homelessness (2 pts)	☐ Suspected Abuse in current placement (2 pts)
☐ Availability of Weapons (2 pts)	☐ Parent w/Severe Chronic Illness (2 pts)	☐ Parent w/ Drug or Alcohol problem (2 pts)
☐ Limited Developmental Capacity to maintain personal safety (2pts)	☐ Sexual Acting Out/Impulsivity – Current or History (2 pts)	☐ Parent w/ Chronic/Acute Mental Ill, Dev. Delay, MR (2 pts)
☐ Aggressive Behaviors (toward others, animals, property) (1 pt)	☐ Drug/Alcohol Use (1 pt)	☐ Lack of Caregiver Supervision and/or Monitoring or Neglect (1 pt)
☐ Resides in High Crime Neighborhood (1 pt)	☐ Negative Peer Involvement and/or Gang activity (1 pt)	☐ Anorexia/Bulimia (1pt)
☐ Suspended, Expelled, Dropped Out of School (1 pt)	☐ Family Conflict (1 pt)	☐ Truancy (1 pt)
☐ Known/Suspected Criminal Activity (1 pt)	☐ Prejudicial Thinking/Ideation (1 pt)	☐ Limited Ability to Control Anger (1 pt)
☐ Unrestricted Internet Access (1 pt)	☐ Impulsive Behavior (1 pt)	☐ Emotional/Educational Disabilities (1 pt)
☐ Depression – Current or History (1 pt)	☐ Held Back/Behind in Grade level (1 pt)	☐ Difficulty Accepting Supervision/Instruction (1 pt)
☐ Youth with severe chronic illness (1 pt)	☐ Youth with chronic/acute Mental Ill, Dev. Delay, MR (1 pt)	☐ Stealing (1pt)
☐ Enuresis/Encopresis (1 pt)	☐ Self-esteem Problems (1 pt)	☐ Lying (1pt)
☐ Destruction of property (1pt)	☐ Hygiene Problems (1 pt)	☐ Other (describe): _____ _____ (1 pt)

Before submitting a funding request, there must be a meeting with 1 other entity that the family is involved with. These items **must be complete** and then submitted for review:

- The Referral
- Release of Information
- Funding Request
- At-Risk Tool Assessment
- Meeting Minutes
- Sign-In Sheet