Referral Packet



Perry County, Ohio

Family & Children First Council

Together…Helping Families

Revised 10/2018

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Referral Packet Attachments

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**Perry County Family & Children First Council**

Service Coordination Family Team

Referral –Please Ensure All Areas Are Complete

**A. Referral Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Date of Referral:\_\_\_\_\_\_\_\_\_\_\_ | Name of person making referral: | | Click here to enter text. |
| Agency/Relationship to Child: | | Click here to enter text. |
| Address: | Click here to enter text. | |
| Phone Number: | Click here to enter text. | |

**B. Child/ Youth Demographics**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. Last Name: | | Click here to enter text. | | | | First Name: | | Click here to enter text. | | | | |  |  |
| 2. DOB: | Click here to enter a date. | | | | 3. Age: Click here to enter text. | |  | 4. Gender:  M  F  Transgender | | | | | | |
| 5. Race/ Ethnicity: Click here to enter text. | | |  |  | | | | | |  | |  | | |
| 6. Current Living with:Click here to enter text. | | | | | | | | | Relationship to Child/Youth: Click here to enter text. | |  | | | |
| 7.. Who has custody of the Child/ Youth: | | | | | | | | | Relationship to Child: | |  | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 8. Siblings | | | | | 9. Child Current Address:Click here to enter text. | |
| Live With  (check) | Name | | Age | Gender (M/F/O) |  | |
|  | Name:  Name:  Name:  Name:  Name: | Click here to enter text. | Click here to enter text. | Click here to enter text. | Parent address (if different):Click here to enter text. | |
|  | Name:  Name:  Name:  Name:  Name: | Click here to enter text. | Click here to enter text. | Click here to enter text. |  | |
|  | Name:  Name:  Name:  Name:  Name: | Click here to enter text. | Click here to enter text. | Click here to enter text. | 10. Child Phone: \_\_\_\_\_\_\_\_\_\_\_ | |
|  | Name:  Name:  Name:  Name:  Name: | Click here to enter text. | Click here to enter text. | Click here to enter text. | Parent Phone (if different): Click here to enter text. | |
|  | Name:  Name:  Name:  Name:  Name: | Click here to enter text. | Click here to enter text. | Click here to enter text. |  | |
|  | Name:  Name:  Name:  Name:  Name: | Click here to enter text. | Click here to enter text. | Click here to enter text. | 11. Are Parents Employed? Yes No | |
|  | Name:  Name:  Name:  Name:  Name: | Click here to enter text. | Click here to enter text. | Click here to enter text. | If Yes, where: | Click here to enter text. |
|  | Name:  Name:  Name:  Name:  Name: | Click here to enter text. | Click here to enter text. | Click here to enter text. | Work Phone: |  |
| 12. School District of Residence: Click here to enter text. | | | School District of Attendance: Click here to enter text. Grade:Click here to enter text. | | | |
| 13. Family Members & Close Friends to the Youth & Family | | | | | | |
| Name | | | Relationship | | | |
| Click here to enter text. | | | Click here to enter text. | | | |
| Click here to enter text. | | | Click here to enter text. | | | |
| Click here to enter text. | | | Click here to enter text. | | | |
| Click here to enter text. | | | Click here to enter text. | | | |
| Additional Comments | | | | | | |
|  | | | | | | |

**C. Child & Family Team Information**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 1. Who is the Contact Person) for the Service Coordination Family Team-(if different than person making referral) | | | | | | | |
| Name: |  | Agency: |  | | | Phone: |  |
| 2. Best time/method to meet/reach family? | | | |  | | | |
| 3. What agencies are currently involved with the family? Please check all that apply: | | | | | | | |
| Name of Agency Current Team Member (**Check 2nd Box** | | | | | Contact Person | | |
| Mental Health with AllWell, Other | | | | | Click here to enter text. | | |
| Hopewell Health | | | | | Click here to enter text. | | |
| Perry County Help Me Grow/ EI: | | | | | Click here to enter text. | | |
| Perry County Board of DD | | | | | Click here to enter text. | | |
| Perry County Juvenile Court: | | | | | Click here to enter text. | | |
| Perry Behavioral Health Choices | | | | | Click here to enter text. | | |
| Perry County Job & Family Services | | | | | Click here to enter text. | | |
| Ohio Department of Youth Services | | | | | Click here to enter text. | | |
| Perry County Health District | | | | | Click here to enter text. | | |
| Head Start/ HAPCAP | | | | | Click here to enter text. | | |
| Perry County Children Services | | | | | Click here to enter text. | | |
| Integrated Services | | | | | Click here to enter text. | | |
| School IEP at: | | | | | Click here to enter text. | | |
| Other:Click here to enter text. | | | | | Click here to enter text. | | |

**D. Presenting Needs**

|  |
| --- |
| 1. Briefly describe the presenting problem or areas of need (include length of time the problem has been occurring): |
| Click here to enter text. |
| 2. Explain what community resources have been exhausted to ensure least restrictive service implementation: |
| Click here to enter text. |
| 3. Identify the end goal or mission of the family & agencies involved: |
| Click here to enter text. |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **FCFC use only** | | | | | | | | | |
| Date referral received |  | | | Person receiving referral: | | |  | | |
| Date Family Contacted w/outcome: | | |  | | | Outcome of referral: | |  | |
| Risk Assessment Score: | |  | | | Did youth score any “3”(Emergency meeting to be held) | | | | Yes No |

**A**

**AUTHORIZATION FOR EXCHANGE OF INFORMATION**

**Perry County Family & Children First Service Coordination** is authorized to exchange the following (initialed) information regarding \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ \_\_\_\_\_\_\_ (DOB: / \_ / with the Party/Parties (checked) (Name of Child/ Youth) below in order to review the case.

Information Covered: Parties Covered: *(line ~~through~~ any family does not want involved)*

\_\_\_\_\_ Mental Health Evaluations/Diagnosis \_\_X\_ Perry Co. Juvenile Court/Probation

\_\_\_\_\_ Psychological Test Reports \_\_X\_ AllWell

\_\_\_\_\_ Alcohol/Drug Assessment/Diagnosis \_\_X\_ MHRSB

\_\_\_\_\_ Treatment Plan \_\_X\_ Perry Co. Board of DD

\_\_\_\_\_ Medication Records \_\_X\_ Perry Co. Dept. of Job & Family Services

\_\_\_\_\_ Physical Examination/Diagnosis \_\_X\_ Big Brother/ Big Sister

\_\_\_\_\_ Attendance Summary \_\_X\_ Ohio Network for Innovation (ONI)

\_\_\_\_\_ Urinalysis Report \_\_X\_ School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Progress Notes/Reports \_\_X\_ Family & Children First Council

\_\_\_\_\_ Discharge Summary \_\_X\_ Hopewell Health

\_\_\_\_\_ Documents From School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_X\_ Children’s Services

\_\_\_\_\_ Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_X\_ Integrated Services

\_\_X\_ Help Me Grow – Perry County

\_ \_\_X\_ Head Start – Early Head Start - HAPCAA

\_\_X\_ MVESC

\_\_X\_ Perry Behavioral Health Choices

\_\_X\_ Department of Youth Services

\_\_X\_ Perry County Transit

\_\_X\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_X\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child/Youth Dentist:

\_\_X\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child/Youth Physician:

Such disclosure will be for the purpose of: **Perry County Family & Children First .**This authorization may be revoked or the duration changed at any time (except to the extent action has been taken in reliance on it) by providing written notice to the Agency authorized to disclose information, If not previously revoked or changed, this authorization given to **Perry County Family & Children First Service Coordination** will expire in 180 days from date of signature (unless otherwise specified-explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(date in 180 days )

Treatment, payment, enrollment, or eligibility for services may not be conditioned upon signing this authorization; contingent on funding.

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

Signature of Individual Date

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

Witness (Lead/ Referring Agency) Date

***If the family does not agree with the IFSCP or has a complaint with PCFCFC a Dispute Resolution is available for them.*** Agencies that receive information pursuant to this authorization may be entities not covered by federal or state privacy laws. Thus, information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by law, except that any information regarding an individual’s diagnosis or treatment for substance abuse may not be re-disclosed without the individual’s authorization or unless otherwise permitted by 42 CFR Part 2. ***In any case, the Agency disclosing information cannot control the use of information once it has been disclosed.***

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

Signature of Personal Representative, if Applicable Revocation (by individual Date

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

Personal Representative’s Relationship to Individual

Date Individual declined \_\_\_\_\_ \_\_\_ a copy of this form.

**B**

**FidelityEHR- Release**

By signing this form, you are consenting to allow personal health information to be entered into an Electronic Protected Health Information (EPHI) medical file, FidelityEHR. FidelityEHR follows all requirements under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to ensure the confidentiality, integrity, and availability of EPHI, and to mitigate any reasonable risks or hazards to EPHI. Further, FidelityEHR protects against all unauthorized disclosures and manages compliance for all employees, contractors and vendors. Ohio Family and Children First Council (OFCFC) houses the Fidelity HER system for the Perry County Family & Children First Council. Your personal information will not be collected by OFCFC. Only demographic and non-personal identifying information will be collected by OFCFC for data analysis.

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

Parent/ Guardian Date

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

Referring Agency Date