

Alamance County Care Review Referral (Form Updated 10-2009)

ELECTRONIC SUBMISSION REQUIRED: ALL SECTIONS MUST BE COMPLETED!

REFERRAL DATE	CARE REVIEW DATE/LOCATION/TIME
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Emergency: Emergency placements are handled by reconvening the Child & Family Team. A crisis plan for each child should prepare for emergencies. The Care Review Team will review any "emergency out of home placements" at the next available Care Review time following standard referral protocol.

This document is periodically updated by the Alamance County System of Care CFT/Care Review Protocol Committee. This document is designed in an older version of Word (97-2000), thus you may need to save the document to the older version in order to fill in the blanks electronically.

Return this electronic referral as an email attachment to: BRENDA PAGE : bp@acmhdds.org

A separate consent form and explanation have been emailed to you with this referral. The parent/legal guardian must initial all applicable boxes and sign the consent. Fax the consent or mail to:

Brenda Page, Logistics Coordinator – System of Care
319-A N. Graham-Hopedale Road
Burlington, NC 27217
PHONE: (336) 513-4225 FAX: (336) 513-4203

Once all paperwork is received you will be contacted about a Care Review date.

CHILD:

Name of Individual Completing This Referral:

Agency:

Email: Phone:

Name of Supervisor Approving Request for Any Out of Home Placement:

This case has been staffed within this agency and was approved for submission to Care Review.

Supervisor's Signature: _____

Care Review is a multi-disciplinary team established by the Community Collaborative with representatives from the major child-serving agencies who in certain scenarios, review the plan that a Child & Family Team have developed, provide guidance and make recommendations where appropriate, to support the efforts of the Child & Family Team. The goal of the Care Review Team is to help Child & Family Teams build wraparound services that will help a child be successful in their home and community.

There are three scenarios that require presentation to the Team. Please select the appropriate box(es) and describe how you believe that the Care Review Team might best assist your Child & Family Team.

<u>Reason For Referral</u>	<u>Brief Explanation:</u>
<input type="checkbox"/> Requesting Out-of-Home Placement lasting longer than 30 days. PLEASE NOTE: MST and/or Intensive In-Home must have been provided without positive outcome and an out-of-home placement is viewed by the Child & Family Team as the last resort.	
<input type="checkbox"/> Review of Step Down Plan following 30 days in an out of home placement. Transition plan should be in place and presented a minimum of 30 days before a youth is scheduled to return to our community in order to provide them the best opportunity for success.	
<input type="checkbox"/> Child & Family Team Requests Assistance Efforts have not produced the expected outcome and the CFT requests help in brainstorming other options.	

DEMOGRAPHICS

Child's Name: (Use First Name & Last Initial)		DOB:	
Sex:	Race:		
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Caucasian <input type="checkbox"/> Other		
Legal Guardian (If Parent, Use First Name & Last Initial)			
Child currently lives with whom?			
Street:			
City:	State	Zip:	

Placement the Child & Family Team is pursuing?

What is the projected length of stay within the placement?

Funding for Placement (Check):

Medicaid NC Health Choice Other Specify:

Funding for Room/Board (Check)

DSS CMSED SSI Parent(s) Adoption Subsidy

STRENGTHS/SUPPORTS/GOALS
What are the client & family's strengths and supports?
What are obstacles to family involvement?
What existing informal support system strengths are in place?
What formal support system strengths are in place?
List long-term goals the family is seeking and what will success look like?
What are the short-term goals specific to placement and what will success look like?
Name & identify relationship of all Child & Family Team Members:

AS A PART OF THIS REFERRAL YOU MUST FAX COPIES TO SUE WARD AT (336) 513-4203 OF:

- 1. Most current Child & Family Team meeting minutes**
- 2. Page 1 of this form with the supervisor's signature**

List dates and attendees at the last four Child & Family Team Meetings regarding this case.	
Date	<u>CFT Members</u>

Please note that a Child & Family Team must be meeting before a case can be referred to Care Review. A Child & Family Team includes professionals working with the child, the parent/legal guardian, the child when appropriate and any supports the family wants to invite to the table. A CFT should not be confused with a treatment team staffing.

Do all members of the Child & Family Team understand the reason this case is being presented at Care Review? Were they all a part of the decision to present this case?

Are all members of the Child & Family Team in agreement with the plan that is being shared with the Care Review Team?

Are there safety concerns for this child?

No Yes

If yes, please explain:

What steps have been taken by the Child & Family Team to address safety in the home?

If out of home placement is requested explain the events that necessitate this placement:

What is the primary goal of the CFT for this child & family? (This is not the program or a type of service)

Is this the same goal/outcome the child & family are seeking?

Is the goal reachable, measurable and developed with the family?

Is there a crisis plan* developed and being utilized? Yes No

* Please bring copies of the Crisis Plan to the Care Review.

If NO, explain why:

What services would be needed in order to support this child/adolescent remaining in the community?

Home	
School	
Community	

MENTAL HEALTH HISTORY

DSM IV Diagnosis:

Full Scale IQ:

CURRENT MEDICATIONS:

Name of Medication	How Long Taken?

LIST ALL PSYCHIATRIC HOSPITALIZATIONS:

Facilities	Length of Stay

TREATMENT SERVICES RECEIVING/RECEIVED:

TYPE	Provider	Duration
Residential <input type="checkbox"/> Yes <input type="checkbox"/> No		
CS QP (Case Manager) <input type="checkbox"/> Yes <input type="checkbox"/> No		
CS AP (CS Professional) <input type="checkbox"/> Yes <input type="checkbox"/> No		
CS PP (CS Paraprofessional) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Individual <input type="checkbox"/> Yes <input type="checkbox"/> No		
Family <input type="checkbox"/> Yes <input type="checkbox"/> No		
Intensive In-Home <input type="checkbox"/> Yes <input type="checkbox"/> No		
Respite <input type="checkbox"/> Yes <input type="checkbox"/> No		
Other - Specify <input type="checkbox"/> Yes <input type="checkbox"/> No		
Other - Specify <input type="checkbox"/> Yes <input type="checkbox"/> No		

LEGAL HISTORY

Offenses:

Current Legal Status

At Risk Diversion Contract Pending Adjudication Pending Disposition Probation
 Protective Supervision YDC Commitment Post Release Adult Probation Parole

Any Pending Court Dates: Yes No If yes, when and for what charges?

Recent Detention Placement? Yes No If yes, when and why:

SCHOOL/VOCATIONAL HISTORY

Name Of School Currently Attending & Location/Address

School Contact

Last Grade Completed	Course of Study (if high school)	Exceptional Children's Classification	Date of most recent IEP:

Is there a current behavioral plan?
What is the educational transition plan:
Disciplinary actions received (include suspension, expulsions, etc.)
Vocational Training Received (specify program & location)
Employment History <input type="checkbox"/> Not Applicable

PLAN FOR TRANSITION BACK INTO THE COMMUNITY

What is the transition/discharge plan for this child?
Where will the family counseling occur? How will the client be involved in family counseling?
How will positive community connections/resources be maintained while the child is in placement?
How will progress be evaluated while the child is in the placement facility? What are the target behaviors and how will the Child & Family Team know that the child is ready to return to the community?

What services and supports will be in place to ensure a successful transition back into the home and community?	
Services	Supports

If this child is in the custody of DSS, how will this therapeutic placement relate to the client's permanency plan?

Name of DSS Caseworker: _____

Any additional comments: