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|  | **INTENSIVE SERVICES PRESENTATIONS FORM**  **GEAUGA COUNTY FAMILY FIRST COUNCIL**  **12611 RAVENWOOD DRIVE, SUITE 150**  **CHARDON, OH 44024** |

**Please contact Council’s Service Coordinator, Lori Babik at** **(440) 285-1203 or** [**Lori.Babik@jfs.ohio.gov**](mailto:Lori.Babik@jfs.ohio.gov) **to discuss the case you would like to present prior to filling out this form.**

**This form must be filled out in its entirety for all presentations and submitted a minimum of 5 business days prior to the scheduled presentation date set with Lori.**

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| Name of youth being presented: |  |

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| **REASON FOR PRESENTATION**  Junior Bridges  Senior Bridges  Crossroads Health  ENGAGE FFT (Functional Family Therapy)  IHBT (Intensive Home-Based Treatment)  MST (Multisystemic Therapy)  Out-of-home placement  A difficult case for direction/suggestions  Other: |

**The following components are necessary for any intensive service presentation to go forward. The presenter is responsible for ensuring the following are completed prior to the presentation:**

* Was family invited to the meeting? Yes  No
* Was family informed they could bring a support person? Yes No
* Is the family interested in having a Geauga Family First Council Parent Rep attend the meeting as a peer support?  Yes  No If yes, please contact Tim Kehres, [Tim.Kehres@jfs.ohio.gov](mailto:Tim.Kehres@jfs.ohio.gov), 440-285-1201
* Was appropriate school official from the *district of responsibility* notified of the meeting?  Yes  No
* Did presenter notify appropriate staff and all involved agencies? Yes No
* Did the family sign Geauga Family First Council’s Release of Information form? Yes No
* Did the family complete the Family Page? Yes No
* Family was informed about this presentation, provided input, and is aware this information will be shared with the Council’s Inter-Disciplinary Team consisting of, but not limited, to representatives from Geauga County Job & Family Services, Juvenile Court, Ravenwood Health, Family Pride, Catholic Charities, Family & Community Services/Chagrin Falls Park/Next Step, and Metzenbaum/DD Board, as well as potential vendors/service providers. Yes No
* Please include other pertinent information to help the Team better understand the child and their circumstances, such as:

Social History  Probation Report

Psychologicals  School Information/IEP/504/behavioral issues

* Requests for placement:

Must include a letter from the child’s current therapist with a recommendation re: level of care.

1. **Please email the completed request, the signed Release of Information, completed Family Page, and supporting documentation to** [**Lori.Babik@jfs.ohio.gov**](mailto:Lori.Babik@jfs.ohio.gov) ***and*** [**Rachael.Tetlow@jfs.ohio.gov**](mailto:Rachael.Tetlow@jfs.ohio.gov)**.**
2. **Council can convene an Inter-Disciplinary Team meeting on Mondays at 10:30 am or Thursdays at 2:00 pm.**
3. Please encourage the parents/guardians and all treatment team members to participate in the planning and presentation of the case.
4. All opinions regarding the proposed best course of intervention shall be shared.
5. The presenter is the person who will assume primary responsibility for ensuring that services are coordinated and delivered.

Referral Timeline

* + 1. Referral is received from a family member or an agency staff person who is contacted by the next business day by the Service Coordinator.
    2. After determining the appropriateness of the referral, an Inter-Disciplinary Team meeting is usually scheduled within 5 business days.
    3. The case is presented virtually to an Inter-Disciplinary Team via Zoom and the recommendations from the Team hearing the presentation are sent to the presenter and other appropriate parties usually within 5 business days.

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| **Family name:** |  |

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| **Date presented:** |  |

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| **Presenter/person making request:** |  |
| **Presenter’s email address:** |  |

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| **Referral source:** | |  |  | | --- | --- | | Self/Family | Juvenile Justice | | Mental Health/BH Provider | Child Protective Services | | Education | Physical/Hospital | | HMG (E.I. or Home Visiting) | WIC Program | | County Board of DD | HeadStart/Early HeadStart | | OhioRISE | Other : | |

**YOUTH BEING PRESENTED**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name:** |  | | | | |
| **DOB:** |  | | | | |
| **Age:** |  | | | | |
| **Adopted:** | Yes No | | **If yes, has family applied for PASSS funds?** | | Yes No |
| **In JFS Custody:** | Yes No | | **In JFS Prot. Supervision:** | | Yes No |
| **In Foster Care:** | Yes No | | **In Kinship Care:** | | Yes No |
| **Sex:** | Male  FemaleTransgender | | | | |
| **Race:** | |  |  | | --- | --- | | American Indian or Alaska Native | White or Caucasian | | Asian | Mixed Race | | Black or African American | Other | | Native Hawaiian or Other Pacific Islander | Declined to specify | | | | | |
| **Mental health diagnosis:** |  | | | | |
| **Current medications:** |  | | | | |
| **Is the youth compliant with their medications:** | | Yes No  Other: | |  | | |

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| **Is the youth eligible for Medicaid?**  **If yes, has the family applied for OhioRISE?** | Yes No  Yes No |
| **Please provide any additional details re: OhioRISE application:** |  |

**EDUCATION INFORMATION**

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| --- | --- |
| **School District of RESPONSIBLITY:** |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name of school currently attending:** |  | **On an IEP?** |  | **On a 504?** |  | **Current grade level** |
|  |  | Yes  No |  | Yes  No |  |  |

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| **Are there truancy issues?** If yes, please explain: |  |

**BACKGROUND INFORMATION**

**Has the youth had a strength-based assessment?**

If yes: **CANS CASII**   Initial  Follow-up **[please attach]**

If no: has the youth had a risk/safety assessment? Yes  No Type:

**Is there a Safety/Crisis plan currently in place?** Yes  No **[please attach]**

**Is there an Individual Family Service Plan (IFSP) / ITP (Individualized Treatment Plan)** **currently in place?**

Yes  No **[please attach]**

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| **TREATMENT TEAM MEMBERS:** |
| (JFS Case Worker, Probation Officer, Mental Health Case Worker, Therapist, OhioRISE, etc.)  Please provide name, affiliated agency, and email address. |
|  |

**In which of the following areas did the youth/family have needs, whether or not those needs are being addressed:**

|  |  |  |  |
| --- | --- | --- | --- |
| Mental Health | Special Education | Child Abuse | HMG Early Intervention |
| Alcohol/Drug | Physical Health | Child Neglect | Developmental Disabilities |
| Poverty | Unruly | Delinquent | Autism Spectrum Disorder |

**Which of the following agencies are involved with the youth/family at the time of referral:**

|  |  |
| --- | --- |
| Board of Developmental Disabilities | Child Protective Services |
| Juvenile Justice | JFS (if receiving services besides Child Protective Services) |
| Rehabilitation and Corrections | Mental Health/BH Services |
| Office for Ohioans with Disabilities | Education (any level) |
| WIC/BCMH | Help Me Grow Early Intervention |
| CASA | Help Me Grow Home Visiting |
| OhioRISE | Other: |

**HOUSEHOLD INFORMATION**

**ALL household members (first & last names) Age Relationship to Youth**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
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| **Family address:** |  |
| **Parent/Guardian phone number:** |  |
| **Best time/day to contact:** |  |
| **Parent/Guardian email address:** |  |

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| **If youth is being presented for the BRIDGES Program, please provide the following which will be used to determine Medicaid eligibility re: transportation services to/from the BRIDGES program:**   |  |  | | --- | --- | | **Youth’s Social Security Number** |  | | **12-digit Medicaid Number (if applicable)** |  | |

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| **REASON FOR REFERRAL:**  Must answer each question below |
| **History and precipitating events leading to this referral:**    **What services and supports have been utilized to date:**    **Explain any school behaviors and academics:**    **Any additional information we should know as part of this referral?** |

**Are interpreter services needed to communicate with any members of the household?**  
**Yes No**

If yes – please explain:

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| --- |
| **ANY ADDITIONAL INFORMATION:** |
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| **VENDOR INFORMATION** |
| |  |  | | --- | --- | | Activity: |  | | Start & end date: |  | | Day(s)/time(s): |  | | Cost (per session/lesson): |  | | Total cost being requested: |  | |  |  | | Vendor/Provider: |  | | Contact person name: |  | | Address: |  | | Phone number: |  | | Vendor email address [REQUIRED]: |  |   Please note: approvals are made for a maximum of 3 months at a time. Geauga Family First Council is tax exempt and unable to prepay for services. Do not take action, make any payments, or purchase anything until after you receive a letter and PO# from Council’s Program Evaluator. Vendors/providers must be willing to become a Vendor with the Geauga County Auditor’s Office and invoice after services have been rendered. We are unable to pay for services already rendered. |

**REQUIRED**

**FAMILY PAGE**

(As Stated by Family)

**FAMILY STRENGTHS**:

**FAMILY NEEDS/PRIORITIES**:

**FAMILY CULTURAL CONSIDERATIONS**:

**DO YOU HAVE ANY SPECIAL FAMILY TRADITIONS THAT YOUR FAMILY PARTICULARLY LIKES TO DO TOGETHER?**

**FAMILY DREAMS/VISIONS/DESIRES**:

**WOULD YOU LIKE A FAMILY FIRST COUNCIL FAMILY REP TO COME TO THE MEETING AS AN PEER SUPPORT?**

**\_\_\_ YES \_\_\_ NO**

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

**PARENT/GUARDIAN SIGNATURE PARENT/GUARDIAN SIGNATURE**

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

**DATE DATE**

**Parents are invited to attend the meeting and can bring a support person.**

**GEAUGA FAMILY FIRST COUNCIL**

**12611 Ravenwood Drive, Suite 150**

**Chardon, OH 44024**

**RELEASE OF INFORMATION**

The undersigned, having requested services from the Geauga Family First Council, do hereby give our consent to the agencies listed below releasing information to the Council for use in preparing and implementing an individual family service plan.

**The family members who are covered by this release are:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | DOB: |  |  |  |  | DOB: |  |
|  |  | DOB: |  |  |  |  | DOB: |  |
|  |  | DOB: |  |  |  |  | DOB: |  |

**Communication may be written and/or verbal. My initials indicate those agencies I give permission to release and/or obtain information about myself and/or my family.**

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|  | CASA/GAL |  | Catholic Charities |  | Cleveland Clinic |
|  | Crossroads Health |  | Family Pride |  | Geauga County JFS |
|  | Help Me Grow |  | Juvenile Court |  | Lake Geauga Center |
|  | Metzenbaum / Board of DD |  | OhioRISE |  | Passcode to Parenting |
|  | Premier Behavior Health |  | Ravenwood Health |  | Signature Health |
|  | University Hospitals |  | Windsor Laurelwood |  | WomenSafe |
|  | Doctor/Hospital (Specify): | |  | | |
|  | School (Specify): | |  | | |
|  | Victims’ Advocates (Specify): | |  | | |
|  | Probation (Specify): | |  | | |
|  | Diversion (Specify): | |  | | |
|  | Other (Specify): | |  | | |

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| \_\_\_\_\_\_\_\_\_  **INITIAL** | I authorize the agencies and/or individuals specified above to disclose the information I have initialed below to the other treatment team members specified above. It is understood that the information is requested to assist Council staff in planning services with me and/or in completing an assessment of me. (Initial information to be released below.) |

|  |  |  |  |
| --- | --- | --- | --- |
| Psycho-social History | Psychological Evaluation | Psychiatric Evaluation | Medical Evaluation |
| Medications Prescribed | Discharge Summary | Education/Test Records | Hospitalization Records |
| Treatment Notes | Individual/Family Service Plan | Lab Reports/X-rays | Family First Council Reports |
| JFS Case Plan | Probation Reports | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| \_\_\_\_\_\_\_\_\_  **INITIAL** | I fully understand that my records are protected under federal and state confidentiality regulations and cannot be released or disclosed without my written permission. I understand the reason(s) the information indicated above is being requested.  This authorization and consent will expire 180 days from the date of authorization written below. This consent and authorization may be revoked by me in writing at any time. It must be signed, dated, and delivered to 12611 Ravenwood Drive, Suite 150, Chardon, Ohio 44024. Canceling it applies to that day forward and not to information already shared. |

By signing this form, you are consenting to allow personal information to be entered into two (2) web-based data portals maintained by the State of Ohio: “OASCIS” by Ohio Dept. of Job and Family Services (ODJFS) and “CANS” by Ohio Dept. of Medicaid (ODM). ODJFS and ODM ensure that all information entered meets federal and state confidentiality and security requirements and takes action to mitigate any reasonable risks and hazards. Further, ODJFS and ODM protect against all unauthorized disclosures and manages compliance for all employees, contractors, and vendors.

By signing this form, you are consenting to allow Geauga County Job & Family Services to receive personal information to determine Medicaid eligibility [only for clients referred to the BRIDGES program].

By signing this form, you understand that you are entitled to a copy of Geauga Family First Council’s Dispute Resolution Process. You can access a copy of the process via Council’s website: [www.geaugaffc.org](http://www.geaugaffc.org) or by calling 440-285-1201.

By signing this form, you understand information about your child and family will be shared and discussed with the Council’s Inter-Disciplinary Team consisting of but not limited to representatives from Geauga County Job & Family Services, Juvenile Court, Ravenwood Health, Family Pride, Catholic Charities, Family & Community Services/Chagrin Falls Park/Next Step, and Metzenbaum/DD Board, as well as potential vendors and service providers.

Executed this \_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_

Signatures:

Client: Parent/Guardian (Circle):

Staff Person: Guardian Relationship:

Agency: Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOTICE TO ALL DRUG AND ALCOHOL CLIENTS: This information has been disclosed to you from records protected by federal confidentiality rules (42CFR Part 2). 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 42CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.