|  |  |
| --- | --- |
|  | **PROSOCIAL ACTIVITY / GOODS AND SERVICES**  **REQUEST FORM**  **GEAUGA COUNTY FAMILY FIRST COUNCIL**  **12611 RAVENWOOD DRIVE, SUITE 150**  **CHARDON, OH 44024** |

|  |  |
| --- | --- |
| Name of youth: |  |

**Geauga Family First Council should be considered the payor of last resort. Council funding is intended for multi-system youth living in Geauga County. If a multi-system youth is eligible for Medicaid, the family needs to apply for OhioRISE. While eligibility is being determined, you can apply for FFC funding. Future funding determinations will be dependent on following thru with the OhioRISE application.**

**Form must be submitted a minimum of 2 weeks prior to the start date of the requested activity/service.**

**The following components are required for any prosocial activity/goods and services requests. The presenter is responsible for ensuring the following are completed prior to submitting the request:**

* Did the family sign Geauga Family First Council’s Release of Information form? Yes No
* Family was informed about this request, 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

1. **This form must be filled out in its entirety for all requests. Please email the completed request form, the signed Release of Information, and any 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. One of Council’s Inter-Disciplinary Teams will review prosocial activities/goods and services requests via email to allow services/supports to be put in place quickly.
3. 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 request, an Inter-Disciplinary Team usually reviews the request within 5 business days.
    3. Once the request has been reviewed by an Inter-Disciplinary Team, recommendations from the Team are sent to the presenter and other appropriate parties usually within 5 business days.

|  |  |
| --- | --- |
| **Family name:** |  |

|  |  |
| --- | --- |
| **Date:** |  |

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

**YOUTH BEING PRESENTED**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | | |
| **DOB:** |  | | |
| **Age:** |  | | |
| **Adopted:** | 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: |  |

|  |  |
| --- | --- |
| **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**

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

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

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

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

**In which of the following areas does 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 currently involved with the youth/family:**

|  |  |
| --- | --- |
| 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**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

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

|  |
| --- |
| **REASON FOR REFERRAL:** |
| Describe (“paint the picture”) why this youth is being referred and the benefits of the requested service and/or supports. Provide a brief history, including other services and resources utilized and exhausted. Briefly explain any school behaviors and academics. Provide the youth and family strengths. Are there any safety concerns? |

|  |
| --- |
| **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. |

**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.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | 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): | |  | | |

|  |  |
| --- | --- |
| \_\_\_\_\_\_\_\_\_  **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

|  |  |
| --- | --- |
| \_\_\_\_\_\_\_\_\_  **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.