

McNulty Center for Children and Families

Children's Case Management Referral and Intake Assessment

Grayed areas of form are to be completed by CSB staff

Referral Information: Completed by: Name: _____ Date: _____ Signature: _____ Credentials _____ Agency: _____ Telephone#: _____	Intake Assessment: Completed by: CSB Staff Name/Title: _____ Date: _____ Location: _____ Length of Session: _____
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II. Identifying Data:

A. Youth

1. Name: _____ Gender : _____ Male _____ Female
2. Age: _____ Race: _____ Birth Date: _____
3. Social Security #: _____ Medicaid # _____
4. Address: _____
5. School: _____ Grade: _____
6. Special Education Services: _____ Yes _____ No
7. Disabling Condition: _____

B. Family Information:

1. Mother: _____ Phone: _____
Address: _____
2. Father: _____ Phone: _____
Address: _____
3. Sibling: _____ Age: _____
4. Sibling: _____ Age: _____
5. Sibling: _____ Age: _____
6. Sibling: _____ Age: _____
7. Other Significant People: _____

Additional Information gathered at Intake: _____

III. Social History:

A. Presenting Problem(s):

Additional Information gathered at Intake:

B. Pertinent Background Data:

1. Alcohol/Substance Use: _____ No _____ Yes (Explain): _____

Additional Information gathered at Intake:

2. Financial Issues: _____ No _____ Yes (Explain): _____

Additional Information gathered at Intake:

Child's Name: _____

3. Housing / Environmental Issues: ___NO ___ Yes (Explain):_____

Additional Information gathered at Intake:_____

4. Developmental Issues: _____ No ___ Yes (Explain):_____

Additional Information gathered at Intake:_____

5. Physical/Sexual Abuse: _____ No ___ Yes (Explain):_____

Additional Information gathered at Intake:_____

6. Family Relationship Issues: _____ No ___ Yes (Explain):_____

Additional Information gathered at Intake:_____

7. Family Functioning Issues: _____ No _____ Yes (Explain): _____

Additional Information gathered at Intake: _____

8. Custody Issues: _____ No _____ Yes (Explain): _____

Additional Information gathered at Intake: _____

9. Cultural Factors: _____ No _____ Yes (Explain): _____

Additional Information gathered at Intake: _____

10. Social Functioning Issues: _____ No _____ Yes (Explain): _____

Additional Information gathered at Intake: _____

Child's Name: _____

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11. Legal /Court Involvement: _____ No _____ Yes (Explain): _____

Additional Information gathered at Intake: _____

12. Medical Issues: ____ No ____ Yes (Explain): _____

Additional Information gathered at Intake: _____

13. Psychiatric/ Mental Health: ____ No ____ Yes (Explain): _____

Additional Information gathered at Intake: _____

14. Significant Life Events: ____ No ____ Yes (Explain): _____

Additional Information gathered at Intake: _____

15. Housing and Environmental Issues: ___ No ___ Yes (Explain): _____

Additional Information gathered at Intake: _____

16. Miscellaneous: _____

Additional Information gathered at Intake: _____

C. Steps Taken to Solve Problem/s to Date:

1. _____

Additional Information gathered at Intake: _____

2. Other Agencies Involved:

(a.) Agency: _____
Contact : _____ Phone: _____

(b.) Agency: _____
Contact : _____ Phone: _____

(c.) Agency: _____
Contact : _____ Phone: _____

(d.) Agency: _____
Contact : _____ Phone: _____

Child and Family Worksheet

Strengths and Successes of Youth:

1. What are the youth's interests and abilities?

2. What significant relationships does the youth have?

3. What family and social supports exist for the youth?

4. What services did the youth respond positively to?

5. What are the youth's achievements?

6. What are the most positive settings for the youth?

7. Describe the youth's peer relationships:

Strengths and Successes of the Family:

1. What are the family's interests and abilities:

2. Who is significant in and around the family?

3. What family and social supports exist for family?

4. What services did the family respond positively to?

5. What are the family's achievements?

6. Describe the family's relationship with other families:

C. Youth and Family Needs (Please describe in measurable terms i.e. improve school grades, reduce conflicts with peers, participate in substance abuse treatment, comply with curfew, locate employment, etc.):

D. Which is the area of highest need? _____

E. Which services/s do you think would be most helpful? _____

Youth's Signature

Date: _____

Parent/s Legal Guardian Signature

Date: _____

DX: _____

Current GAF: _____

Case- Management Services is recommended ___No ___Yes (if yes, complete the following)

Case Management is recommended to address the following areas of need: _____

Staff Signature & Credentials

Date

Child's Name: _____

Please complete the following form, the **Authorization to Use and Disclose Personal Health Information** form. A signed copy of this form will allow for the exchange of information between McNulty Center staff and other involved agencies during the referral meeting and will facilitate access to Harrisonburg –Rockingham Community Services Board’s Children’s Case Management services.

1. Complete with the parent / legal guardian.
2. Review checked boxes with parent/guardian
3. Obtain an authorizing signature from the parent/legal guardian.
4. Sign as a witness to the parent/ legal guardian signature.
5. Attach Authorization to Use and Disclose form to Referral form and bring all completed information with you to assessment and planning team meeting at the McNulty Center.

For questions, feel free to contact Cathy Allen at the McNulty Center, 540-433-3100.

**Harrisonburg Rockingham Community Services Board
McNulty Center for Children and Families
Authorization To Use and Disclose Personal Health Information (PHI)**

I _____, am signing this form for _____
 (Full Printed Name/s of authorizing Person/s) (Full Printed Name of Client)

Client's Address: _____ Client's Date of Birth: _____ Client's SSN (optional): _____

My relationship to the client is: Self Parent Power of Attorney Guardian Other Authorized Representative

I hereby authorize the McNulty Center for Children and Families to: *(check all that apply)*

disclose to exchange with obtain from

The following Agencies:

- | | |
|--|--|
| <input checked="" type="checkbox"/> Your Agency's Name: _____ | <input checked="" type="checkbox"/> Harrisonburg City Public Schools |
| <input checked="" type="checkbox"/> Harrisonburg-Rockingham Dept. of Social Services | <input checked="" type="checkbox"/> Rockingham County Public Schools |
| <input type="checkbox"/> 26 th District Juvenile & Domestic Relations Court | |
| <input type="checkbox"/> Harrisonburg-Rockingham Family Assessment & Planning Team (FAPT) | |
| <input type="checkbox"/> Harrisonburg-Rockingham Community Policy and Management Team (CPMT) | |
| <input checked="" type="checkbox"/> Additional Agencies if Applicable (write in): _____ | |

The following information:

- | | | |
|---|---|---|
| <input checked="" type="checkbox"/> Assessment Information | <input checked="" type="checkbox"/> Medical Diagnosis | <input checked="" type="checkbox"/> Educational Records |
| <input checked="" type="checkbox"/> Financial Information | <input checked="" type="checkbox"/> Mental Health Diagnosis | <input checked="" type="checkbox"/> Psychiatric Records |
| <input checked="" type="checkbox"/> Benefits/ Services Needed | <input checked="" type="checkbox"/> Psychological Records | <input checked="" type="checkbox"/> Medical Records |
| <input checked="" type="checkbox"/> Planned and/or Received | | |
| <input type="checkbox"/> Other Information: _____ | | |

The information may be used and disclosed by means of: (check all that apply)

- Written/Mail Verbal/Telephone Fax

As the person signing this authorization, I acknowledge that I am giving permission to have the above named organization to disclose and use my protected health information (PHI). I have been informed that:

- I may refuse to authorize the release of this information.
- The provision of treatment/services is not conditioned upon my signing this authorization.
- Unless revoked, this authorization will expire 30 days post discharge from this agency.
- I have the right to revoke this authorization at any time except to the extent that action has been in reliance on it. The revocation will stop the listed agencies from sharing information once they have been informed that the authorization has been withdrawn.
- I have the right to know what information has been shared, including why, where, when and with whom it was shared. If asked, each agency will provide this information.

I want all listed agencies to accept a copy of this form as a valid authorization to share information. If I do not sign this form, information will not be shared and I will have to contact each agency individually to give them information about me that they need.

Signature(s): _____ Date: _____
 Authorizing Person(s)

Person Explaining Form: _____
 Name Title Phone #

Witness (if required): _____
 Signature Address Phone #

There is a potential for any information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and therefore, no longer protected by the provisions of the HIPAA Privacy Rule. If this information is being disclosed from records protected by the Federal substance abuse confidentiality rules (42 CFR part 2), the Federal rules prohibit the recipient from making any further disclosures of this information unless further disclosure is expressly permitted by your written authorization or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Authorization Revoked on _____ by _____ / _____
 Date Printed Name Signature

UNIFORM AUTHORIZATION TO USE AND DISCLOSE

Full Printed Name of Client: _____

For Agency Use Only

Authorization Has been:

Revoked in entirety:

Partially revoked as follows: _____

Notification that authorization was revoked was by:

Letter (attach copy) Telephone In person

Date Request Received: _____

Agency Representative Receiving Request:

(Agency representative's full name)

(Agency address and telephone number)

Listed agencies have been notified of revocation by means of:

Letter (attach copy) Telephone In person