FOR CASSP USE ONLY

Lycoming-Clinton CASSP

Children and Adolescent Service System Program

Lycoming Office:
200 East Street
Williamsport, PA 17701
(570) 326-7895

Clinton Office
8 North Grove Street
Lock Haven, PA 17745
(570) 748-2262

Individuals completing this referral for a CASSP meeting must also submit a completed CASSP release of information form (see attached). The information release must include any public/private agencies and schools that are involved with the child and/or family. Information contained in this form is confidential and should be completed with the consent and knowledge of the child and family.

***Referrals that are not completed in their entirety may be delayed. ***

INTAKE PACKET

CHILD DEMOGRAPHIC INFORMAITON

Name:_____ **MAID:**_____

DOB:_____ **Age:**_____ **Sex:**_____ **Race:**_____

Address:_____ **Phone Number:**_____

City:_____ **County of Residence:**_____

Zip:_____ **Primary Language:**_____

Does a translator need to be provided by school/organization: _____

INSURANCE INFORMATION

Insurance: HealthCHoices/CCBH _____ Private Medical Insurance _____ Fee-For-Service _____

Notes on Insurance:_____

Reason for Referral (choose minimum of one):

____ School Attendance
____ Service Coordination
____ Educational Placement
____ Behavior Support
____ Behavior Home/Community
____ Other:_____

____ Service Compliance
____ Medical Issues
____ Team Planning
____ Services Ineffective
____ More Services Needed

Is MH Case Management involved: _____
Agency:_____
Contact:_____
IQ: _____ Above 70 _____ Below 70 _____ Unknown

Please describe the behaviors/incident which led to making the CASSP referral:

Parent/Guardian Information

1. **Name:**_____ **Role:**_____ **DOB:**_____

   Address:_____

   Phone:_____ **Email:**_____

2. **Name:**_____ **Role:**_____ **DOB:**_____

   Address:_____

   Phone:_____ **Email:**_____

3. **Name:**_____ **Role:**_____ **DOB:**_____

   Address:_____

   Phone:_____ **Email:**_____

Is there a current Custody Agreement/Court Order: _____

Specify Type of Custody Agreement/Court Order:_____

Please be prepared to provide a copy of the Custody Order. Providers will require consent from all partied who have legal custody of child.

Additional Members Residing in Household:

	Name	Relationship	Age	Phone Number
1.				
2.				
3.				
4.				
5.				

NOTES:

SCHOOL INFORMATION

School District:_____ Grade:_____

School Building/Alternative Placement:_____ Dates of Placement:_____

Primary School Contact:_____ Title:_____

Other School Representatives:_____

Does the child receive any of the following (check all that apply):

____ Emotional Support _____ Learning Support _____ Autistic Support _____ Life Skills _____ 1:1 Aide

____ Speech _____ Occupational Therapy _____ Physical Therapy _____ 504 Plan _____ IEP (Individualized Education Plan)

Has there been a Functional Behavioral Assessment (FBA) completed: _____ Date:_____

Please attach any school feedback: 504 Plan, IEP, ODRs (Office Disciplinary Report), Behavioral Plans, Attendance Information, Report Cards, and FBA (Functional Behavioral Analysis)

Please provide any additional school information and/or concerns:

Protective Factors

Please List the Child or Adolescent's Strengths:

Please List the Family's Strengths:

Please List the Member/Family's Community Supports:

MENTAL HEALTH SERVICE INFORMATION

Previous Service History:

	Service Type	Provider	DOS	Further Note
1.				
2.				
3.				
4.				
5.				

Please provide any additional Notes:

Does your child receive any of the following (check all that apply)

Children and Youth Services (CYS)

Current Involvement _____ **Contact: _____**

Reason for Involvement:

Past Involvement: _____ **Contact: _____**

Reason for Involvement:

Juvenile Probation (JPO)

Current Involvement _____ **Contact: _____**

Reason for Involvement:

Past Involvement: _____ **Contact: _____**

Reason for Involvement:

Substance Use Disorder Services (SUD)

Current Involvement _____ **Contact: _____**

Reason for Involvement:

Current Service History:

Diagnosis:_____ **Date of recent Assessment/Evaluation:_____**

	Service Type	Provider	DOS	Assigned Worker
1.				
2.				
3.				
4.				
5.				

NOTES:

Medication:

Psychiatrist: _____ **Most Recent Medication Visit:_____**

Current Medications:

	Medication Name	Dosage	Prescriber	Notes:
1.				
2.				
3.				
4.				
5.				

Comments Regarding Medication:

Family History of Mental Illness:

PHYSCIAL HEALTH INFORMATION

Primary Care Physician (PCP):_____ **Provider:_____**

Date of most recent Physical/Examination:_____

Please rate the child's health: _____ Good _____ Fair _____ Poor

Did the child/adolescent meet developmental milestones: _____

Does the child/adolescent have any Serious Illness/Diagnosis/Predisposing Factors that impact behavior:

Other Specialist:

NOTES:

RISK ASSESSMENT

Is the child/adolescent a victim of:

Past _____ Current _____

____Physical Abuse _____ Emotional Abuse _____ Neglect _____ Sexual Abuse _____ Domestic Violence

NOTES:

Is the child/adolescent a perpetrator of:

Past _____ Current _____

____Physical Abuse _____ Emotional Abuse _____ Neglect _____ Sexual Abuse _____ Domestic Violence

NOTES

Is the child currently SI/HI:_____ **Notes:_____**

Does the child have a history SI/HI:_____ **Notes: _____**

Is there a family history of SI/HI: _____ **Notes: _____**

SI = Suicidal Ideation **HI = Homicidal Ideation**

Please List Any Additional Information or Concerns

What Is the Desired Outcome of CASSP Involvement:

Scheduling: ***Please indicate any times of days, days of week, or barriers to scheduling.***

CASSP Support Meetings may occur via agency, school, virtual, or agency.

Please indicate your preference: _____

Submit completed packets via encrypted email, mail, fax, or in person

Referral Source:_____ **Title/Role:** _____ **Date:** _____

Phone Number: _____ **Email:** _____

Has a Release of Information (ROI) been completed or provided: _____ **Date:**_____

CASSP SUPPORT CONTACT LIST

NAME	AGENCY	ROLE/TITLE	PHONE	EMAIL