Interagency Screening Committee
Of
St. Lawrence County

Request for Screening And Release Of Information

Name of Child: ____
Current Address: ____

I am requesting that my Child's referral packet be submitted to the Single Point of Access Committee to determine eligibility for in home and community based services. I understand that the screening committee includes representatives from St. Lawrence Psychiatric Center, Department of Social Services, Probation, the Public School System, Coordinated Children's Services Initiative, BOCES, St. Lawrence County Outpatient Clinic, Office of People with Developmental Disabilities, Cerebral Palsy Association, The Children's Home of Jefferson County, United Helpers Mosaic, Transitional Living Services and the Youth Advocate Program.

I also understand the referral packet will be checked for completeness and someone from the committee may need to contact me, the referral source or another agency for further clarification, or to request additional documentation.

I believe my child qualifies for In Home and Community Based Services because he/she:

- Is under the age of 21 and
- Has a serious emotional & or behavioral disturbance and/or
- Has two chronic conditions and/or
- Complex trauma and/or
- Is at risk of out of home or psychiatric placement and has mental health needs;
- Has service and support needs that cannot be met by just one agency;
- Can be served in the community if provided appropriate access to services;
- The family is willing to participate in services and support the child so that he/she may remain at home and in the community.

I understand that if my child is provided services as a result of this screening process, he/she will participate in one of these services: Health Home Care Coordination, the Coordinated Children's Services Initiative, or Home and Community Based Services Waiver. The decision regarding the level of service will be based on the screening committee, the referral source and the family determination of the best level of service to meet the needs of the child/youth and family.

I give permission for members of the screening committee to share information regarding my child, in order to determine eligibility for In Home and Community Services.

Parent/Guardian Signature: ____
Parent/Guardian Name (print): ____
Child's Signature (if applicable): ____
Date: ____

Withdrawal of Request

I voluntarily withdraw the request for an initial screening of my child's eligibility for these services. I understand that this withdrawal does not jeopardize his/her current treatment or any future requests for screening. All information forwarded for review will continue to be maintained in a confidential manner.

Parent/Guardian Signature: ______________________ Print Name: ______________________
Witness Signature: ______________________ Print Name: ______________________
Child's Signature: ______________________ Print Name: ______________________
Date: ______________________

Referred to: (please check all that you prefer)			
☐ **Coordinated Children's Services Initiative**			
☐ **Health Home Care Coordination**			
☐ **Home and Community Based Waiver Services**			

Individual Being Referred			
Name:	**Sex:**	**DOB:**	**Age:**
Race/Ethnicity:	**Primary Language:**		
Address:	**Phone:**		

Living Environment/Support System	
Parent/Guardian's Name:	**Phone:**
Address:	
Parent/Guardian Enrolled in the Health Home Program: ☐ Yes ☐ No	
Relationship to Child: ☐ Biological Parents ☐ Adoptive Parents ☐ Other Family/Legal Guardian ☐ Local DSS ☐ DFY ☐ Emancipated Minor	
Current Living Situation: ☐ Independent Living ☐ Two-Parent Family ☐ One-Parent Family ☐ Two-Parent Adoptive Family ☐ One-Parent Adoptive Family ☐ Relative's Home ☐ DSS Foster Care ☐ OMH C&Y Community Residence ☐ Crisis Shelter ☐ Residential Treatment Center ☐ Residential Treatment Facility ☐ Psychiatric Inpatient Care ☐ Jail ☐ Homeless ☐ Other:	
If in Residential/Psychiatric Setting Anticipated Discharge Date:	

Referred By		
Name:	**Title:**	**Agency:**
Address:	**Phone:**	
Email:	**Fax:**	

Financial and Insurance Information			
Type of Health Coverage			
☐ Private ☐ VA/Military Benefits ☐ Other ☐ None ☐ Medicaid: ID #: ☐ Eligible ☐ Application Pending ☐ Not Applied			
Income			
SSI:	**SSD:**	**Child Support:**	**Other:**

Other Agency Involvement
☐ Mental Health (specify): ☐ Inpatient ☐ RTF/CR ☐ Day Treatment ☐ Clinic ☐ Unknown ☐ Juvenile Justice ☐ Family Court ☐ Juvenile Welfare (specify): ☐ Foster Care ☐ Prevention ☐ Child Protection ☐ Unknown ☐ Other

Educational Information

Classification By the Committee on Special Education:

☐ No Conditions ☐ Emotionally Disturbed ☐ Learning Disabled ☐ Sensory Impaired
☐ Physically Disabled ☐ Other Health Impaired ☐ Multiply Handicapped ☐ Not Classified ☐ Unknown

Present Educational Placement:

☐ Regular Class in Age-Appropriate Grade ☐ Regular Class, Behind At Least One Grade
☐ Special Class for Students With Handicapping Conditions ☐ Vocational Training Only
☐ Residential School for the Educationally Handicapped ☐ Part-Time Vocational/Educational
☐ Not Enrolled in School ☐ High School Graduate/GED ☐ Day Treatment ☐ Home Instruction
☐ BOCES ☐ Other (specify)

Mental Health Diagnosis/SED Criteria

ICD 10 Code	Description

Symptoms/Behaviors

(Indicate degree to which child exhibits the following symptoms/behaviors)

Symptom/Behavior	Not Present	Mild	Moderate	Severe
Depressed Mood				
Anxiety/Nervousness				
Suicidal Symptoms (attempts, threats, ideation)				
Mood Swings				
Anger/Temper Tantrums				
Hyperactivity (problems with attention, destructible, impulsive)				
Aggressive Behavior (physical, sexual, etc)				
Irritability				
Psychotic Symptoms (hallucinations, delusions, bizarre behaviors)				
Obsessive/Compulsive Behaviors				
Sleep problems				
Elimination Problems (bowel, bladder)				
Eating Problems				
Phobias/Fears				

Symptoms/Behaviors Continued	Not Present	Mild	Moderate	Severe
Cruelty to Animals				
Fire Setting				
Inappropriate Sexual Behavior/Acting Out				
Antisocial/Delinquent Behavior				
Runaway/Escape Present Living Situation				
Problems in Current Living Situation				

Other Disabilities

Symptom/Behavior	Not Present	Mild	Moderate	Severe
Developmental Delays				
Learning Disability				
Physical Handicap				
Blind				
Visually Impaired				
Deaf				
Hard of Hearing				
Speech Impairment				
Other (specify)				
Mental Retardation				
Disabling or Life Threatening Medical Condition				
Alcohol				
Substance Abuse (specify)				

Indicate Degree to Which Child's Behavior is Currently Impaired Due to Emotional Disturbance

Life Domain	Not Effected	Impairment Mild	Impairment Moderate	Impairment Severe
Self-Care (adequate personal hygiene/ability to perform age appropriate chores/tasks)				
Social Relationships (ability to establish/maintain satisfactory relationships w/peers/adults)				
Family Life (capacity to live within a family)				
School Performance/Learning Ability (satisfactory attendance, able to function in learning environment, completes assignments)				

Self-Direction (behavioral controls, decision-making, judgement, value system)				

Indicate Risk Factors Which Apply Either Past or Present			
Risk Factor	**Not Applicable**	**Past History**	**Current Evidence**
Significant Psychotic Symptoms (hallucinations, delusions, bizarre behaviors)			
Suicidal Symptoms (attempts, threats, ideation)			
Sexually Abused			
Physically Abused			
Complex Trauma			
Physical or Medical Neglect			
Psychological or Social Neglect			
Self-Destructive Behaviors			
At Risk of Psychiatric Placement or Other Out of Home Placement			
At Risk of Causing Personal Injury or Property Damage			
HIV/AIDS			

Additional Detail Related to Items Checked in Areas Above:

Mental Health Treatment History (Hospital/Residential Name, Dates of Service, Treatment)

Current Service Needs (Describe service needs, barriers to those needs, complex health/mental health needs. Identify any strengths (child & family) and informal support systems in place.)

Signature of Referral Source (Include printed name, signature, title, and date.)

Signature:	**Date:**

St. Lawrence County
In-Home and Community Based Family Services
Safety Information

*Are there Safety issues around this person or others in the household?

☐ Yes ☐ No

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*Who resides in the home? (please use names and relationship to child):

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*Are there animals at the home (please list)?

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*Have any of these animals bitten or attacked anyone?

☐ Yes ☐ No

*If yes please explain:

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*Are there firearms, swords or weapons in the home?

☐ Yes ☐ No
*If yes please explain:

SAFETY ISSUES ARE ADDRESSED TO ENSURE THAT PROVIDERS CAN
SAFELY GO INTO THE HOME