Cumberland-Perry
MH.IDD
Mental Health . Intellectual & Developmental Disabilities

CASSP Involvement: CASSP meetings are a voluntary process, guardians must be contacted about the referral and be in agreement with it. Before completing the referral, please call the office to discuss the purpose of a CASSP meeting. Sometimes, we can resolve a need or an issue without a meeting, depending on the situation. Likewise, the referral may not be appropriate for CASSP.

CASSP Meeting Referral Form

Child's Information:

Name: _____ Social Security #: _____

Date of Birth: _____ Age: _____ Sex: _____

Insurance: _____

Child's Address: _____

Guardian's Information:

Guardian Name: _____ Cell Phone #: _____

Address: _____
(If different from above)

Email: _____ Best Way to Contact: _____

Guardian Name: _____ Cell Phone #: _____

Address: _____
(If different from above)

Email: _____ Best Way to Contact: _____

List the other individuals residing in the household:

Name	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What is the reason for the CASSP Referral? Describe the current situation and challenges/behaviors of the child within the home, school, and community. *Please be specific.* **NOTE: (Please do not type beyond the end of the line, the font will get smaller and unable to read. At the end of each line, please tab to the next line to begin typing. Use additional page if needed):**

What is the desired outcome of the CASSP Meeting for the following stakeholders?:

Guardian:

Provider:

School:

Please list the strengths and interests of the child and family:

What significant people or community organizations other than agencies (i.e., natural supports) are being utilized to support the child at this time?:

Social and Family History: **NOTE:** **(Please do not type beyond the end of the line, the font will get smaller and unable to read. At the end of each line, please tab to the next line to begin typing.)**

_____
_____
_____
_____
_____

List past home/community services tried:

Type of Service:	Provider:	Dates:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Barriers to accessing services/resources: **NOTE:** **(Please do not type beyond the end of the line, the font will get smaller and unable to read. At the end of each line, please tab to the next line to begin typing.)**

_____
_____
_____

Current Medications:	Dosage:	Prescribing Physician:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

School Information:

Home School District: _____ Grade: _____

School Name: _____ Classroom Setting: _____
(Regular Ed., ES, LS, etc.)

List any other school services currently involved: _____
_____
(Speech Therapy; Personal Assistance, Physical Therapy, Occupational, etc.)

Please include: *(referral will be considered incomplete until records are received)*

☐ A recent evaluation and/or treatment plan

☐ School Evaluation Report/Individualized Education Program

☐ Psychiatric, Psychological, and/or Neuropsychological Evaluations

Invitation List

Name of Person Completing this form: _____ Agency: _____

Contact person for the child at your agency (if different than above): _____

Phone #: _____ Email: _____ Best Way to Contact: _____

Other Involved Agencies: (C&Y Services, School Staff, Mental Health, Intellectual and Developmental Disabilities Drug & Alcohol, Juvenile Probation, PerformCare, extended family/natural supports, etc.):

_____ _____
Primary Contact Relationship/Title

_____ _____ _____
Agency Phone # Email Address

_____ _____
Primary Contact Relationship/Title

_____ _____ _____
Agency Phone # Email Address

_____ _____
Primary Contact Relationship/Title

_____ _____ _____
Agency Phone # Email Address

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Primary Contact Relationship/Title

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Agency Phone # Email Address

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Primary Contact Relationship/Title

_____ _____ _____
Agency Phone # Email Address

_____ _____
Primary Contact Relationship/Title

_____ _____ _____
Agency Phone # Email Address

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CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Child's Name: _____

Date of Birth: _____

I hereby authorize the following agencies or individuals to participate in the CASSP meeting:

School District (specify):

_____

Alternative School:

_____

Other Agencies *(providers, psychiatrist, CYS, etc):*

_____

_____

Other Supports *(family, friends, relatives, mentors, etc):*

_____

_____

I also authorize the disclosure of the following documents or reports relevant to the named individual above:

☐ Psychological Reports ☐ Progress Reports ☐ Treatment Plans

☐ Psychiatric Reports ☐ Physician Reports ☐ Medical Records

☐ Social & Family History ☐ School/academic records ☐ Behavior Plans

Please note the CASSP Core Team consists of the following professionals: Capital Area IU, Cumberland/Perry County CYS, Cumberland/Perry County JPO, Penn State Holy Spirit, Cumberland/Perry D&A, Cumberland/Perry County MH/IDD, Merakey Stevens Center, PerformCare MCO, CPARC, and Perry Human Services. Information at the CASSP meeting will be held in strict confidence and used for the purpose of assessment of needs, planning, and coordination of services, and evaluation of progress and effectiveness of services. The CASSP Core Team will not disclose any information to any agency or service provider and all materials gathered at the CASSP meeting will be collected at the end of the meeting and shredded. The CASSP Coordinator will assist with treatment teams & families identified in the aftercare service plan.

This authorization will expire in one year subsequent to the date of signature, unless revoked by a written request of the consumer (if over the age of 14) or consumer's parents or legal guardian.

_____	_____	_____
Signature of Consumer if 14 or older	Begin Date	End Date
_____	_____	_____
Signature of Parent or Guardian	Begin Date	End Date
_____	_____	_____
Witness	Begin Date	End Date

_____

Verbal Consent: We, the undersigned, certify that the above-named consumer and legal guardians understand the nature and provision of this authorization and has freely given his/her verbal consent in lieu of signature.

_____	_____	_____	_____
Signature of Witness	Title	Begin Date	End Date
_____	_____	_____	_____
Signature of Witness	Title	Begin Date	End Date