

Family Frontier System of Care Referral/Information Packet

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The Family Frontier System of Care Project is a comprehensive spectrum of services, which provides support to children and adolescents with mental, emotional and behavioral impairments and to their families. Services are child centered, family-focused and community based.

The following criteria are the guidelines for involvement:

- The child must be between the ages of preschool and 20
- The child must live in Cleveland or McClain Counties and have a parent, guardian, or foster parent living in Cleveland or McClain Counties
- The child must have a diagnosable emotional and/or behavioral disorder
- The child must have significant issues that have or are expected to last for a year or more due to his/her serious emotional and/or behavioral disturbance
- The child needs, has received, or has requested services/support from two or more support systems
- The child must be at risk of out of home or school placement due to the impact of the serious emotional and/or behavioral disturbance
- The family volunteers for this service and agrees to actively participate in the process.

An interdisciplinary review team, the Clinical Review Team, will review the referral and make the determination of approval into the Family Frontier System of Care. Upon approval, a Care Coordinator who coordinates the needed wraparound services will contact the family.

INSTRUCTIONS:

The following referral form and release must be read and filled out completely by the referral source and the parent/guardian. The parent/guardian's initials by the following bullets and signature on the accompanying release must be present for the referral to be considered by the Review Team.

- The following referral form will be reviewed by an interdisciplinary review team for approval into the Family Frontier System of Care Project. The Clinical Review Team consists but may not be limited to representatives from the following agencies: Central Oklahoma Community Mental Health Center, Oklahoma Youth Center, Department of Human Services, Office of Juvenile Affairs, Cleveland County Health Department, Crossroads Youth and Family Center, Garvin/McClain County Youth and Family, Crossroads Head Start/Early Head Start, Moore Youth and Family, NAIC, Center for Children and Families, local school systems, and parent representatives.

Parent/Guardian's Initials _____

- If the referred child is approved for the Family Frontier System of Care an additional release will be obtained from the parent/guardian in order that periodic review of the wraparound services can be monitored by the Clinical Review Team.

Parent/Guardian's Initials_____

- If the referred child is not approved for the Family Frontier System of Care, the family will be referred to other possible services and the release becomes null and void.

Parent/Guardian's Initials _____

Oklahoma Systems of Care Initiative Referral Form

Referring Agency: _____ Date of Referral: ____ / ____ / ____

Referring Person: _____ Phone: _____

Original referral source, if different from above: _____

Youth Information

Name: _____ SSN: ____ - ____ - ____ Date of Birth: ____ / ____ / ____ Age: ____

Race/Ethnicity: _____ Sex: ____ School: _____ School Phone: _____

Caregiver Name: _____ Relationship to Child: _____

Address: _____

City: _____ County: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Indicate if the youth is:

DHS: Involved In custody DHS worker/phone: _____ / _____

OJA: Involved In custody OJA worker/phone: _____ / _____

In substance abuse or mental health treatment Agency: _____ Phone: _____

Receiving other services (specify): _____

On medications (please list): _____

Initial Screening – Please check all that apply

- The youth has behavioral/emotional symptoms that suggest a diagnosable emotional disorder.
- The youth has a significant difficulty that has lasted or is expected to last for a year or more due to her/his serious emotional disturbance.
- The youth needs, has received or has requested services or support from two or more systems.
- The youth is at risk of out-of-home placement or out-of-school placement due to the impact of the serious emotional and/or behavioral disturbance.
- The youth and her/his parent, guardian or foster parent reside in a county served by the Oklahoma Systems of Care Initiative.

The family volunteers for this service and agrees to participate actively.

General mental health / diagnosis comments

Risk Factors *(please check all that apply)*

Youth Factors

- | | |
|---|--|
| <input type="checkbox"/> Runaway / leaving home without permission | <input type="checkbox"/> Chronic illness |
| <input type="checkbox"/> Withdrawal from family, social activities | <input type="checkbox"/> Self-abusive behavior |
| <input type="checkbox"/> Recent dramatic changes in eating habits, sleep pattern or body weight | <input type="checkbox"/> Repeated incidents of lying, stealing, property destruction |
| <input type="checkbox"/> Age or developmentally inappropriate bed-wetting or soiling | <input type="checkbox"/> Physical aggression toward authority figures, family members, peers |
| <input type="checkbox"/> Inappropriate sexual behavior | <input type="checkbox"/> Intentionally hurts others |
| <input type="checkbox"/> Perpetrator of sexual abuse | <input type="checkbox"/> Intentionally hurts animals |
| <input type="checkbox"/> Victim of sexual abuse | <input type="checkbox"/> Sets fires |
| <input type="checkbox"/> Victim of physical abuse | <input type="checkbox"/> Involvement in criminal activity |
| <input type="checkbox"/> Use or abuse of alcohol or drugs | <input type="checkbox"/> Declining school grades, truancy, poor attendance |
| <input type="checkbox"/> Attempted suicide or suicidal thoughts | <input type="checkbox"/> School suspensions / expulsions |
| <input type="checkbox"/> Hallucinations – aural, visual or tactile | <input type="checkbox"/> Developmental delays |
| <input type="checkbox"/> History of inpatient psychiatric hospitalization(s) | <input type="checkbox"/> History of neglect |

Caregiver / Family Factors

- | | |
|---|---|
| <input type="checkbox"/> Chronic physical illness in family

<input type="checkbox"/> Family history of mental illness, psychiatric hospitalization or substance abuse

<input type="checkbox"/> Suicide attempts

<input type="checkbox"/> Victim of physical abuse (other than youth)

<input type="checkbox"/> Victim of sexual abuse (other than youth) | <input type="checkbox"/> Parental incarceration

<input type="checkbox"/> History of domestic violence

<input type="checkbox"/> Poverty

<input type="checkbox"/> Other children in foster care

<input type="checkbox"/> Youth exposed to substance abuse in the home |
|---|---|

Members of the Youth's Household

Name	Relation to Youth	Age	Name	Relation to Youth	Age

Other Information

How can this youth and her/his family benefit from their involvement with Systems of Care? _____

What other information about the youth and her/his family do you feel would be helpful to Systems of Care staff?

Referred Youth's Medicaid # (if applicable) _____

Please list some of the strengths of this child and family.

Home:

Transportation:

Financial/Insurance:

Educational/Vocational:

Social Supports/Spirituality:

Leisure/Talents/Skills:

Health: