Great Plains Systems of Care

REFERRAL PACKET

Clinton Office	***Watonga Office:***	***Elk City Office:***
Red Rock West BHS	*Red Rock West BHS*	*Red Rock West BHS*
90 N. 31st Street	*216 West "A" St.*	*3080 W. 3rd Street*
Clinton, OK 73601	*Watonga, OK 73772*	*Elk City, OK 73644*
(580) 323-6021	(580)623-7199	(580) 225-5136

Enclosed is a referral packet to be completed by the caregiver or provider of services for a child that is extremely emotionally distressed. The services provided to the family will involve extended family members, family, friends, clergy, school personnel, various social service providers, and others identified by the child or family as being supportive.

Goals of Great Plains Systems of Care:

1. **We hope to assist the family in managing crises more effectively, reduce the frequency of the personal crises occurring in the home, and improve relationships among family members and others supportive of the family.**

2. **We hope to assist the family in developing a strong support system that can be relied on long after the family has graduated from Great Plains Systems of Care.**

If you believe that Great Plains Systems of Care would benefit a child in your care, in your community, or for whom you are a provider of services, please fill out the attached sheets to provide us with information about the child. Great Plains Systems of Care will contact you for a follow-up shortly after the referral is received.

After the follow-up, the referral will be taken to the Great Plains review team at which time a determination will be made to either accept the child or assist the child and family in finding alternative services. The referral source and referred family will be promptly notified of the review team's decision.

Please Return Referral to: Jennifer Davis, *Project Director*
Great Plains Systems of Care
90 N. 31st Street
Clinton, OK 73601
Phone: (580) 323-6021 Ext. 2245 or Fax: (580) 323-0828
Web Site: www.gpsoc.com

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: _____

Alternate Phone Number _____ Relationship _____

Indicate if the youth is:

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

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

School: Grade _____ ☐ Receiving Special ED Services ☐ Special ED Category _____

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

Receiving other services (specify): _____

_____

_____

On medications (please list): _____

_____

_____

Prescribing Physician: _____ Date Last Seen: _____

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 resides 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

_____

_____

_____

_____

Psychiatric Evaluation Date: _____ **Evaluated By:** _____

Risk Factors ***(please check all that apply and add comments for explanation)***

Youth Factors

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

Caregiver / Family Factors

- ☐ Chronic physical illness in family
- ☐ Family history of mental illness, psychiatric hospitalization or substance abuse
- ☐ Suicide attempts
- ☐ Victim of physical abuse (other than youth)
- ☐ Victim of sexual abuse (other than youth)
- ☐ Parental incarceration
- ☐ History of domestic violence
- ☐ Poverty
- ☐ Other children in foster care
- ☐ 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?

_____

_____

_____

_____

_____

RED ROCK BEHAVIORAL HEALTH SERVICES
AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION

I, _____ _____ _____ _____
(Name of Client) (Date of Birth) (Social Security #) (Chart #)

HEREBY AUTHORIZE:

RED ROCK BEHAVIORAL HEALTH SERVICES _____

_____

_____

TO COMMUNICATE & EXCHANGE INFORMATION WITH:

(Referral Source): GPSOC Review Team, DHS, OJA, Youth & Family, Graduated Parent, Custer County Schools, Washita County Schools, Blaine County Schools, Beckham County Schools, Roger Mills County Schools ___

The information indicated below for the following purpose(s) (Client must initial or check):

_____ Treatment planning
_____ Submission of court/progress reports
_____ Insurance Eligibility/health benefits
_____ Responsible Party/Family Member/Emergency Contact
_____ Follow-up
_X_ Other (specify) Referral for GPSOC and Ongoing Evaluation

PERIOD OF TIME COVERED BY INFORMATION TO BE RELEASED: _____

METHOD OF RELEASE (please check all that apply): ☐ Fax ☐ **Written** ☐ **Verbal** ☐ Video ☐ Audio

REPORTS TO BE FURNISHED (Client must initial or check):

____ Psychosocial Assessment
____ Health & Medication History
____ Alcohol & Other Drug Information
____ Intake Assessment (Part II)
_____ Medication Record
_____ Progress Notes
_____ Treatment Plans
_____ Psychological Testing
_____ Discharge Summary
_X_ Other Referral
_____

Notice to recipients of alcohol and drug abuse records:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains 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 rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

The information you authorize for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, tuberculosis, and the human immunodeficiency virus (HIV), also know as Acquired Immune Deficiency Syndrome (AIDS). Further, the information authorized for release may indicate the presence of communicable or no-communicable disease (63 O.S. § 1-502-2).

Clients referred by the Criminal Justice System – The information disclosed may only be redisclosed to carry out the recipient's official duties with regard to the client's criminal proceeding in reference to which the consent to release confidential information was made by the client.

I understand that my records are protected under the Federal and State Confidentiality regulations and cannot be released without my written consent unless otherwise provided for in the regulations. Federal regulations prohibit Red Rock Behavioral Health Services from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. I also understand that I (or my legally authorized representative) may revoke this consent (in writing) at any time by contacting a Red Rock staff member unless action has already been taken. A photocopy of this authorization shall be considered as valid as the original. This consent will expire when all third (3) party payer claims are satisfied or not to be exceeded one year from the date signed. (For clients who have been referred by the Criminal Justice System, this consent expires no later than the date of final disposition of any criminal proceedings).

I further understand that my treatment services are not contingent upon, or influenced by, my decision to permit the information release, and by signing below, I indicate that my consent to the release of this information is given freely and voluntarily.

_____ _____
Client's Signature Date

_____ _____
Signature of Witness Date

_____ _____
Signature of parent, guardian, or authorized representative Date
(Relationship to Client _____)

REC-104 Rev.8/08

Client Name _____ Chart # _____

Wraparound
AGREEMENT OF PARTICIPATION

I, _____ as a supportive individual of _____,

Do agree to the following:

1. A ***FAMILY TEAM** will be developed within one month based on the family's strength assessment.

2. As a **FAMILY TEAM** member, I will schedule regular family team meetings and will cancel in advance if necessary.

3. It is highly recommended that one **FAMILY TEAM** member be from the school and/or the referring source.

4. I will assist the entire family in using the Crisis Plan set forth in the **FAMILY TEAM** meeting.

5. Confidentiality agreement can be broken in the instances of threats of harm to self or others, child abuse or by a court order.

6. If the custody of client is anyone but parent or state agency, that party must have representation on the client's **FAMILY TEAM**.

7. In order for this process to be beneficial there should be NO family secrets.

8. If there is no family team decisions regarding use of flex funding and a family budget when required, no flex funding will be allocated.

By signing this agreement, I agree to participate in **FAMILY TEAM** meetings and to positively influence the goals set forth by the **FAMILY TEAM**.

_____
Team Member

*A family team is people you choose who are supportive of you. There should be more family and friends than professionals on the team.

Letter of Collaboration Between

_____ and _____
(Facility A) (Facility B)

It is agreed that _____ and _____
(Facility A) (Facility B)

will collaborate on services provided to _____
(Client's Name)

Recipient ID # ___ ___ ___ ___ ___ ___ ___ ___ ___, for the duration of the attached prior authorization request.

This collaboration occurs through two service plans (Facility A service plan and Facility B service plan) developed collaboratively by the facilities' treatment teams. Each facility retains clinical control of and responsibility for its portion of the treatment. The progress in treatment will be coordinated through inter-agency staffing and consultations. The signatures of the respective clinicians below constitute agreement to collaborate.

_____ _____
Facility A Clinician, Credentials Date Facility B Clinician, Credentials Date

As a client, I agree to this treatment approach.

_____
Client (14 or older) Date

As the parent/guardian of _____, I agree to this treatment approach.

_____
Parent/Guardian (and Relationship to Client) Date

The anticipated/estimated division of services is as follows:

	Facility A	Facility B
Type of Service	Hours per month	Hours per month
Individual Psychotherapy	_____	_____
Family Psychotherapy	_____	_____
Group Psychotherapy	_____	_____
Individual Psychosocial Rehab	_____	_____
Group Psychosocial Rehab	_____	_____
Case Management	_____	_____
_____	_____	_____
Other (specify)		

This is an estimate subject to negotiated change and is included here for reference purposes.