

CASSP

Franklin & Fulton Counties

Child & Adolescent Service System Program

Kimberly Lucas, CASSP Coordinator

425 Franklin Farm Lane, Chambersburg, PA 17202

phone: 717.709.2307

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Some history & the role of CASSP

- CASSP began in Pennsylvania over 20 years ago when funding was provided for each county to hire a CASSP coordinator.
- Many CASSP Coordinators serve a variety of functions in their counties.
- CASSP is a philosophy and it also serves as a resource to families, agencies, schools, etc. when assistance with services may be needed.



referrals & other info

It's best to contact the CASSP Coordinator to ensure that the referral is appropriate and that CASSP is not currently involved.

Releases are required from parents/those over age 14 are needed in order to get the process moving and to share information.



Involvement in CASSP is voluntary.

CASSP will sometimes be asked to get involved by the managed care company when a child is recommended for a higher level of care, there are multiple agencies involved or there is a need for help with a transition back to the community (discharge planning).

High Profile Cases are often referred to CASSP for coordination and collaboration.

CASSP meetings can be...

- one-time only meetings
- problem-solving meetings or for times when your team is "stuck" or has differences of opinions re services and/or treatment needs
- for a child who is at risk of out-of-home placement *
- on-going, regularly scheduled review meetings for high profile cases
- discharge planning meetings for transitioning back to the community, etc.
- transition-planning meetings for youth who are aging out of the children's service system and into the adult system



Some benefits of CASSP...

- sharing & communication of information among the interagency team
- problem solving, brain storming
- offers support for the family and agencies involved
- finding other services/programs that could be beneficial
- helps to look at the big picture & the future
- discussing and working through systems issues
- other benefits





Franklin/Fulton Mental Health
 Child & Adolescent Service System Program
 CASSP Referral Form

Kimberly Lucas, CASSP Coordinator
 425 Franklin Farm Lane, Chambersburg, PA 17202
 phone: 717-709-2307 fax: 717 263-0469

CASSP Involvement: CASSP is a voluntary process, so parents must be contacted about your referral and be in agreement with it. Second, before completing the referral, please call me so we can discuss the expectations 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, or I may already have a current referral/open case for the child.

Child's Information

name: _____ MA id #: _____

date of birth: _____ age: _____ sex: _____ race: _____

Insurance: Perform Care? yes / no Private medical insurance? yes / no

Where is child currently residing: _____

Parent's Information

Mother's name: _____ cell phone: _____

address: _____ home phone: _____

town: _____ zip: _____ work phone: _____

email: _____ best way to contact? _____

Please explain the mother's level of involvement with the child:

Father's name: _____ cell phone: _____

address: _____ home phone: _____

town: _____ zip: _____ work phone: _____

email: _____ best way to contact? _____

Please explain the father's level of involvement with the child:

List the significant individuals in the child's life and others residing in the household:

name	relationship	age	does this person reside in the home with the child?
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Please list the strengths and interests of the child and family:

What is the reason for this CASSP Referral:

What is your desired outcome of CASSP involvement?

Describe the current situation and challenges/behaviors of the child at home, at school, etc.
Please be specific. (use back or additional page if needed)

School information

school: _____ contact person: _____

role: _____ phone: _____ email: _____

grade: _____ teacher: _____ what is the child's IQ: _____

What type of classroom/education setting is the child in? _____
(example: regular ed., ES, LS, etc.)

List any other school services that are involved (example: speech therapy, personal assistant, PT, OT, etc.)

List the current home/community services and agencies involved with the child and family:

service/agency

contact person

Please indicate past services, significant background information, previous treatment that was provided to the child and family and any other information about the child and family that would be helpful.

Scheduling the CASSP Meeting: It is difficult at times to schedule a meeting that includes everyone, depending on the number of people involved, schedules of the family, professionals involved, travel time, school availability, etc. Therefore, please indicate your suggestions/preferences on when we should or could meet: (For instance, if parents work all day, we may need an evening appointment or if there is a meeting already scheduled, perhaps we could combine meetings.)

Name of Person completing this form: _____ agency: _____

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

address: _____

phone: _____ email: _____ best way to contact: _____

additional notes or information

Please also include:

_____ a recent evaluation and/or treatment plan

_____ High Profile sheet

And be sure you have a Release of Information in order to give me all of this information.

If you have any questions, contact me.

Please send all documents via mail or fax or deliver in person to

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Please do not email the referral as it is private health information and email is not secure.



Franklin/Fulton County CASSP
Consent to Release Confidential Information

I hereby authorize Franklin/Fulton CASSP and the following organizations as marked to release information to and receive information from:

<input type="checkbox"/> Franklin County Children & Youth	<input type="checkbox"/> School District:
<input type="checkbox"/> Fulton County Children & Youth	<input type="checkbox"/> School District:
<input type="checkbox"/> Franklin County Juvenile Probation	<input type="checkbox"/> Intermediate Unit:
<input type="checkbox"/> Fulton County Juvenile Probation	<input type="checkbox"/> Guardian Ad Litem:
<input type="checkbox"/> Franklin/Fulton Mental Health/Intellectual Disabilities	Please list all others below:
<input type="checkbox"/> Franklin/Fulton Drug & Alcohol Program	<input type="checkbox"/>
<input type="checkbox"/> Franklin/Fulton Early Intervention	<input type="checkbox"/>
<input type="checkbox"/> Tuscarora Managed Care Alliance -TMCA	<input type="checkbox"/>
<input type="checkbox"/> Perform Care	<input type="checkbox"/>
<input type="checkbox"/> SAM – Service Access & Management	<input type="checkbox"/>

from the record of _____

Name		Birthdate
_____		_____
Address		Zip
_____		_____

The following information will be exchanged for the purpose of referral/case coordination (select all that apply):

<input type="checkbox"/> Psychiatric / Psychological reports	<input type="checkbox"/> Vocational skills assessment
<input type="checkbox"/> Teacher observations / School records	<input type="checkbox"/> Social History / Family Information
<input type="checkbox"/> Progress Reports	<input type="checkbox"/> Attendance Data
<input type="checkbox"/> Medical Reports	<input type="checkbox"/> Report Cards
<input type="checkbox"/> Neurological Reports	<input type="checkbox"/> Admission / Discharge Reports
<input type="checkbox"/> IQ test scores, aptitude and achievement tests	<input type="checkbox"/> Behavior Reports
<input type="checkbox"/> CASSP referral and summary	<input type="checkbox"/>

*This release is valid for 12 months from the date of signature and may be revoked by notifying the Franklin/Fulton CASSP Coordinator in writing or witnessed verbally. **I understand that treatment, payment, enrollment or eligibility for benefits and services is not subject to signing this release. However, I choose to sign this release voluntarily to receive CASSP coordination services. I have read this form carefully and understand what it means.***

 Signature of Minor (age 14 and above) Date

 Signature of Parent or Guardian (Relationship) Date

 Signature of Witness Date

 *** Signature of Witness Date

Verbal release of information (***requires signature from two witnesses): *This section is to be used for consumers who are unable to provide a signature. We have witnessed that the consumer understands the nature of this release and has freely given his/her consent.*



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In accordance with Pennsylvania Regulations: "This information has been disclosed to you from records whose confidentiality is protected by State Law. State regulations limit your right to make any further disclosure of this information without the prior written consent of the person to whom it pertains."