Franklin/Fulton Child and Adolescent Service System Program
CASSP Referral Form

Date: _____

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/Adolescent Information

Name: _____ MA ID #: _____

Preferred Name: _____ Preferred Pronouns: _____

Date of Birth: _____ Age: _____ Sex: _____ Race: _____

Address: _____

Insurance: PerformCare? Yes ☐ No ☐ Private Medical Insurance? Yes ☐ No ☐

Where is child currently residing: _____

Parent/Guardian Information

Parent/Guardian: _____ Phone: _____

Address: _____

Email: _____ Best way to contact: _____

Parent/Guardian's level of involvement:

_____

Parent/Guardian: _____ Phone: _____

Address: _____

Email: _____ Best way to contact: _____

Parent/Guardian's level of involvement:

_____

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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?

What is the reason for this CASSP Referral?

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)

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

What is your desired outcome of CASSP involvement?

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CASSP Referral Form

School Information

School: _____

Contact Person: _____ Title: _____

Phone: _____ Email: _____

Grade: _____ What is the child's IQ (if known)? _____

What type of educational placement is the child in? _____
(Example: Regular Education, Emotional Support, Learning Support, etc.)

List any other school services that are involved.
(Example: Speech Therapy, Physical Therapy, Occupational Therapy, Personal Assistant, etc.)

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

Service/Agency	Contact Person

What previous services have been tried? Please list below the type of service, provider, and approximate dates of the services:

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CASSP Referral Form

Scheduling the CASSP Meeting: 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/Adolescent at your Agency *(If different than above):* _____

Address: _____

Phone: _____ Email: _____ Best way to contact: _____

Additional Notes or Information

Please include a recent evaluation and/or treatment plan.

The release of information included in this packet must be completed.

If you have any questions, contact me. Documents can be sent via mail, fax, delivered or sent through secure email. If you do not have secure email, please reach out to me and I can initiate a secure email chain.

Nancy Strueber, CASSP Coordinator
425 Franklin Farm Lane, Chambersburg, PA 17202
Email: njstrueber@Franklincountypa.gov
Phone: 717-709-2307 | Fax: 717-263-0469

FRANKLIN COUNTY, PENNSYLVANIA
AUTHORIZATION FOR THE RELEASE
OF HEALTH INFORMATION

Client Name: _____ Date of Birth: _____

Client ID #: _____

Today's Date: _____

PART 1. Identifying Information

I, _____**[print name]**, hereby authorize the following persons or department of Franklin County, Pennsylvania

- ☐ Mental Health/Intellectual Disabilities/Early Intervention
- ☐ Children and Youth
- ☐ Area Agency on Aging
- ☐ Drug and Alcohol
- ☐ Privacy Officer
- ☐ Other: _____

to release information from my records as specified below, to:

Name of Person/Entity: _____

Address (or email address): _____

I authorize the information to be released as indicated on **Part 3** of this form, and for the purpose(s) set forth therein.

Part 2: Acknowledgments

- I understand that the Authorized Information may be re-disclosed by the recipient and may no longer be protected by federal or state law.
- I understand that I have the right to revoke/withdraw this authorization, in writing, at any time by notifying the HIPAA Privacy Officer of Franklin County, Pennsylvania, and that the revocation/withdrawal will be effective except to the extent that Franklin County, Pennsylvania has already taken action in reliance on my authorization.

My written statement that I want to revoke/withdraw my authorization should be delivered to: HIPAA Privacy Officer, Franklin County, 218 N. Second Street, Chambersburg, Pennsylvania 17201.

- I understand that Franklin County will not condition my treatment or access to services upon whether or not I sign this Authorization. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my access to treatment or services by or through Franklin County.

This authorization will expire at the earlier of _____[Date] or the date the following event occurs:

(Describe event or otherwise write not applicable) _____

Signature of Client:

_____(Signature) _____(Date)

_____(Print Name)

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here (attach any additional verifying information):

Personal Representative:

_____(Signature) _____(Date)

_____(Printed Name)

Part 3: Information to Be Released and Purpose of Release (Complete Section A or Department-Specific Section)

A. All Departments

Type of Information to be Released:

- ☐ Complete Medical Record
- ☐ Special Consultation
- ☐ Progress Notes (excludes Psychotherapy Notes)
- ☐ Treatment Summary
- ☐ Social History
- ☐ HIV/AIDS Status
- ☐ History
- ☐ Physical
- ☐ Other (specify) _____

Purpose of Release:

- ☐ At the request of the individual (check box if applicable)
- ☐ Treatment
- ☐ Initial Evaluation
- ☐ Case Conference
- ☐ Education Planning
- ☐ Court Evaluation
- ☐ Other (specify)_____

B. Drug and Alcohol

Type of Information to Be Released:

- ☐ Substance Abuse/Alcohol
  - ☐ Diagnosis/Level of Care Recommendation
  - ☐ Client Progress
  - ☐ Client Attendance
  - ☐ Relapse (occurrence/ frequency/outcome)
  - ☐ The nature of the project
- ☐ Other (specify)_____

Purpose of Release:

- ☐ Informing emergency contact in event of emergency
- ☐ Referral for Treatment
- ☐ To monitor the provision of ongoing treatment
- ☐ To enable judges, attorneys, probation/parole officers and/or child welfare agencies to support treatment goals and/or make legal decisions on the client's behalf
- ☐ To obtain insurance, employment or government benefits
- ☐ Referral to support/ancillary treatment services
- ☐ At the request of the individual
- ☐ Other (specify) _____

C. Area Agency on Aging

Type of Information to be Released:

- ☐ Admission/Discharge Dates
- ☐ Presence in Service
- ☐ Medical History and Physical
- ☐ Brief Description of Progress
- ☐ Discharge Summary
- ☐ Psychological Evaluation
- ☐ Psychiatric Evaluation
- ☐ Financial Records
- ☐ Medical Records
- ☐ Medication List
- ☐ Treatment Plans
- ☐ Plan of Care
- ☐ Legal Status
- ☐ Diagnosis
- ☐ Other (specify) _____

Purpose of Release:

- ☐ Coordinate Aftercare Treatment including Level of Care decision
- ☐ Obtain information for a more complete history
- ☐ Coordinate treatment efforts
- ☐ PDA Waiver Application
- ☐ Waiver Service Coordination Activities
- ☐ At the request of the individual
- ☐ Other (specify) _____

D. Mental Health/Intellectual Disabilities/ Early Intervention

- ☐ Intake File
- ☐ IQ Test, Adaptive Behavior Assessment
- ☐ Educational Records
- ☐ Medical Reports/Physical
- ☐ Psychological Evaluation/Re-evaluation
- ☐ Vocational Skills Assessment
- ☐ Discharge Summary
- ☐ Personnel Information
- ☐ Educational Record
- ☐ Medical Records
- ☐ Drug/Alcohol Treatment History
- ☐ Psychiatric
- ☐ Other (specify) _____

Purpose of Release:

- ☐ Case Conferencing
- ☐ Court Evaluation
- ☐ Emergency Contact
- ☐ Initial Evaluation
- ☐ Treatment
- ☐ Early Warning Sign Report
- ☐ Education Planning
- ☐ At the request of the individual
- ☐ Other (specify) _____

****Note to Recipient:**

This information has been disclosed to you from records whose confidentiality is protected by State and Federal Law. Federal Regulation). Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or substance abuse consumer. Federal or state laws may prohibit you 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. A General Authorization for the release of medical or other information is NOT sufficient for this purpose. This release shall be valid for a period no longer than 3 months unless otherwise specified.

☐ If *this box is checked*, the records included with the disclosure of records may contain **HIV-related Records** subject to special privacy protections. As such, be advised that:

> This information has been disclosed to you from records protected by Pennsylvania law. Pennsylvania law prohibits 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 is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.

☐ *If this box is checked*, the records included with the disclosure of records may contain **Mental Health records subject to the Mental Health Procedures Act** subject to special privacy protections. As such, be advised that:

> This information has been disclosed to you from records whose confidentiality is protected by State statute. State regulations limit your right to make any further disclosure of this information without prior written consent of the person to whom it pertains.