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:

_____

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

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?

Franklin/Fulton Child and Adolescent Service System Program
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:

Franklin/Fulton Child and Adolescent Service System Program
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/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:

☐ Franklin County Children & Youth	☐ School District:
☐ Fulton County Children & Youth	☐ Intermediate Unit:
☐ Franklin County Juvenile Probation	
☐ Fulton County Juvenile Probation	***Please list all others below:***
☐ Franklin/Fulton Mental Health/Intellectual & Developmental Disabilities/Early Intervention	☐
☐ Franklin/Fulton Drug & Alcohol Program	☐
☐ Tuscarora Managed Care Alliance (TMCA)	☐
☐ PerformCare	☐
☐ Service Access & Management (SAM)	☐

from the record of _____ _____

Name Birthdate

_____

Address

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

☐ Psychiatric / Psychological Reports	☐ Vocational skills assessment
☐ Teacher Observations / School Records	☐ Social History / Family Information
☐ Progress Reports	☐ Attendance Data
☐ Medical Reports	☐ Report Cards
☐ Neurological Reports	☐ Admission / Discharge Reports
☐ IQ Test Scores, Aptitude And Achievement Tests	☐ Behavior Reports
☐ CASSP Referral And Summary	☐ Other:

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. ***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