

Red Cliff

Coordinated Services team (CST)

Referral Information

Red Cliff Coordinator Services helps families with children or adolescents who have multiple needs. Children involved in the CST process may have needs related to mental health, alcohol and other Drug abuse, Child protection, juvenile justice, or special education.

Referral to CST can be made by teachers, social workers, community members, or other agencies. Children referred to Red Cliff CST must be an enrolled Native American.

Once a referral is made, the family members, referral source, CST coordinator, and potential team members will meet to decide if the CST process will be helpful to the family.

Principles of Coordinated Services

- *Strength-based*
- *Family- focused*
- *Collaborative*
- *Focused on early intervention*
- *Families are full participants in the process*

The CST referral packet can be returned in to:

Nannette Gokee

CST Coordinator for Red Cliff

88385 Pike Rd. Hwy. 13

Bayfield, WI 54814

(715) 779-3769/779-3826

ngokee@redcliff-nsn.gov

Red Cliff
Coordinated Services Team (CST)
Pre-Referral Checklist

If the youth you are considering referring meets the following *criteria*, contact your Tribal CST Service Coordinator: Nannette Gokee, at (715) 779-3769 or 3826 or begin the referral process.

Any family enrolled in Red Cliff, with-in the community and living in Bayfield County.

The child uses (or will) be involved in at least two services provided in the categories of:

- Special Education needs
- Truancy
- Legal
- Mental Health
- Development Disability
- Victim of sexual assault
- Violence within the family
- Juvenile Justice
- Child Protective Services
- Substance abuse within the family
- Alcohol or other Drug Abuse Services
- Ongoing health issues

Other interventions have not been successful or are difficult for the family to use.

Children at risk for out-of-home placement (or those who may be able to return as a result of CST participation) are given priority.

Parent or guardian wants to be a part of the team. Child is risk of out of home/institutional placement.

Red Cliff Coordinated Services Team (CST) Initiative

ELIGIBILITY CRITERIA

Must meet all criteria's listed below:

A child/youth from 0-21 years old.

The child/youth or parent is an enrolled member of the Red Cliff Tribe and is a resident of Bayfield County.

The child/youth lives in a home (biological, relative, adoptive, foster, etc.) or can be expected to return to a home like setting in the community.

Participation in the Initiative is voluntary.

The child/youth is involved in services from more than one system (included, but not limited to: mental health, special education, juvenile justice, child protective services, alcohol and other drug services, special health care needs.)

The family's needs have not been met, or a reasonable determination can be made that their needs will not be met, by traditional community services.

A parent or guardian wants to be a part of the team.

REFERRAL PROCEDURE

1. To obtain a referral form or to talk with someone regarding any questions you may have about the Initiative or whether a youth/family would be appropriate to refer please contact:

Nannette Gokee, Red Cliff CST Service Coordinator

88385 Pike Road, Hwy 13

(715)779-3769 or 779-3826

Email: ngokee@redcliff-nsn.gov

FAX: (715)779-3771

2. Referral forms should be **completed with the family** and include the signed 'Consent for Referral and Participation' page. The referral should be sent to the above person. It can be sent via mail, email or FAX.
3. A Services Coordinator will contact the family within 3-5 days to schedule a Screening meeting. The person making the referral will be asked to attend this meeting.

The screening meeting has three purposes:

- A. To ensure the youth and family understand what the CST initiative has to offer and how the process works.

- B. To identify what assistance the family is seeking and what they would like from being involved in the initiative.
 - C. To mutually decide on whether the CST initiative would be the most appropriate means to meeting the family's needs.
4. If it is decided that involvement in the CST Initiative would not be appropriate, the services provider team will assist the family in obtaining other services.

Red Cliff Coordinated Service Team (CST) Initiative
Consent for Referral and Participation

Name of Referred Child: _____

Date of Birth: _____

I give my consent to _____ to refer my child and family members as identified to the Red Cliff Coordinated Services Team (CST) initiative. I agree to participate in the team process and to play an active role in the assessment and case planning processes.

I understand that I will be asked to identify the service providers working with my family and to sign release forms authorizing the exchange of information. I realize that as long as our family is involved in CST, it will be necessary for service providers to routinely review and share information.

I understand that referral information regarding my child and my family will be shared by the referring person with the Red Cliff Coordinating Service CST Initiative staff for the purpose of determining eligibility for the program.

_____ Date _____

Signature of above Client Child (Required for release of AODA Information if 14 years older or over)

_____ Date _____

Signature of Individual Authorizing Referral

_____ Date _____

Second Authorization/Witness Signature

Red Cliff Coordinated Services Team (CST)

Referral Form

Name of child (include middle initial): _____
Date of Birth: _____ Age: _____ SSN: _____
Funding source (circle): MA, SSI, Katie Beckett, Private Insurance, Parents,
Other (please describe) _____

Please check all that apply:

- Use of multiple direct services (e.g. mental health, special education juvenile Justice, child protective services, alcohol or other drug services)
- Other interventions have not been successful over time, or persistent obstacles to service access and/or need for service coordination exists
- At risk of out of home/institutional placement
- Parents are willing to be involved in the team process

Child's Address: _____

Phone Number: _____

Living With: _____ **Relationship:** _____

List other significant people in the home (please include age and relationship): _____

List other significant people not in the home (please include age and relationship): _____

Complete the following information if different from above:

Parent(s) Name: _____ Home Phone: _____
Address: _____ Work Phone: _____

Referral Person: _____ **Referral Date:** _____

Phone Number: _____

Reason for Referral: _____

Service Provider Information

Does the child have a Mental Health diagnosis?

If **yes**, please complete the remainder of the referral form, including the Severe Emotional Disturbance (SED) Checklist (Appendix A).

If **no**, please complete the remainder of the referral form, and disregard the Severe Emotional Disturbance (SED) Checklist (Appendix A).

Mental Health Provider: _____

Contact Person: _____ **Phone Number:** _____

Describe Involvement:

**Is the child involved with the Juvenile Justice System,
Child Protective Services (CPS), or Alcohol /Other Drug Abuse (AODA) services?**

If **yes**, please complete the provider information below and attach documentation of services (can obtain through the family's social worker).

If **no**, please continue with "Educational Provider" information.

Juvenile Justice, CPS, or AODA Service Provider: _____

Contact Person: _____ **Phone Number:** _____

Describe Involvement:

Educational Provider: _____ **Special Education? Yes No**

Contact Person: _____ **Phone Number:** _____

Other Agency/Provider: _____ **Phone Number:** _____

Contact Person: _____

Describe Involvement: -

Red Cliff Collaborative Systems of Care
CONFIDENTIAL INTERAGENCY INFORMATION RELEASE AUTHORIZATION

Name(s): _____ Birthdate(s): _____

Address: _____ Phone: _____

All agencies/individuals listed below are hereby authorized to release and obtain information from all of the other agencies/individuals listed below:

Agency/Individual : Address: _____ City, State, Zip: _____ Phone #: _____ Fax #: _____	Agency/Individual: Address: _____ City, State, Zip: _____ Phone #: _____ Fax #: _____
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Agency/Individual : Address: _____ City, State, Zip: _____ Phone #: _____ Fax #: _____	Agency/Individual: Address: _____ City, State, Zip: _____ Phone #: _____ Fax #: _____
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Agency/Individual : Address: _____ City, State, Zip: _____ Phone #: _____ Fax #: _____	Agency/Individual: Address: _____ City, State, Zip: _____ Phone #: _____ Fax #: _____
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Agency/Individual
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Address: _____
City, State, Zip: _____
Phone #: _____
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Agency/Individual:
Address: _____
City, State, Zip: _____
Phone #: _____
Fax #: _____

Agency/Individual
:
Address: _____
City, State, Zip: _____
Phone #: _____
Fax #: _____

Agency/Individual:
Address: _____
City, State, Zip: _____
Phone #: _____
Fax #: _____

I, _____ hereby authorize all of the named individuals/agencies listed on page 1 of this document to release and/or obtain from any other of the above named individuals/agencies the following written and/or verbal information/records, unless otherwise specified: mental health assessment and/or treatment; psychiatric evaluation and/or treatment; psychological testing; medical and physical examinations and/or treatment; alcohol and other drug abuse assessment and/or treatment; developmental disabilities assessment and/or case management; Human/Social Service and/or Court records; educational testing, and school records, Other _____.

The purpose or need for the information requested is () Assessment and/or Treatment;
() Case Management Services; () Interagency Coordination,
Other _____.

REDISCLASURE NOTICE: The information that I authorize to be released may be redisclosed by the recipient of the records only if allowed by law. If information is redisclosed, the recipient of the redisclosed information may be controlled by different laws.

YOU'RE RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to be Used or Disclosed – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting

(Red Cliff Coordinated Service Team Program, 88385 Pike Road, Hwy 13, Bayfield, WI 54814, Phone#: (715) 779-3826 E-Mail: nagokee@redcliff-nsn.gov)

Right to Receive Copy of this Authorization – I understand that if I agree to sign this authorization, I will be provided with a copy of it. **Right to Refuse to Sign This Authorization** – I understand I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/ or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. (Exception: To provide care that is done solely for the purpose of creating information to release to another party, in which case care cannot be provided without authorizing disclosure. Authorization is needed to release information to payers for certain mental health services and HIV testing. If I refuse to sign the authorization form for this purpose, I understand I may be responsible for paying the entire bill for these services.) **Right to Revoke This Authorization** – I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the **(Red Cliff Coordinated Service Team Program, 88385 Pike Road, Hwy 13, Bayfield, WI 54814, Phone#: (715) 779-3769 or 779-3826, E-Mail: nagokee@redcliff-nsn.gov)**. I am aware that my withdrawal will not be effective as to uses and/or disclosure of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization.

Expiration date: This authorization is good until one year from the date signed

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

_____ Date _____

Signature of above Client Child (Required for release of AODA Information if 14 years older or over)

_____ Date _____

Signature of Individual Authorizing Release (If signed by other than client state relationship & authority to do so)

Parent Guardian POA for HealthCare Spouse/Adult Family Member of Deceased Patient

All treatment records or spoken information which in any way identifies a client (patient) are considered confidential and privileged to the subject individual in compliance with s.51.30, HFS 92, 42 CFR, Part 2, and 45 CFR Parts 160 and 164. Disclosure without written client (patient) consent or statutory authority is prohibited by law.

PARENT QUESTIONNAIRE

WHAT ARE THE FAMILY GOALS

Parent/s: _____

Date: _____

Does the whole family want to work together as a team including the both biological parents?

What kind of medication is the child taking?

What does he/she like about the school?

What is the typical morning like for your child he/she gets up in the morning?

What goals do you want for your child?

What goals do want for your family?

Give specific examples of difficulties/needs you are asking for support for.

School:

Home:

Community:

Other:

What has the family tried already?

FOR CST OFFICE USE ONLY:

Date Rec'd: _____

Initial Who Rec'd: _____

Eligibility Screening Meeting Date : _____

Enrollment Decision: YES ___ NO ___

Family contact date made regarding decision : _____

APPENDIX A

(Complete if the Child has a Mental Health Diagnosis)

Severe Emotional Disturbance (SED) Criteria Checklist

The child must meet all of the criteria, 1. through 4. below.

Please check all criteria that apply to the child or adolescent you are referring.

1. The child/adolescent must meet all three of the following:

- be a child or adolescent under the age of 21; and
- have an emotional disability that has persisted for at least 6 months; and
- that same disability must be expected to persist for a year or longer.

2. The child/adolescent has an emotional and/or behavioral disability that has been diagnosed by a board certified psychiatrist or clinical psychologist (PhD) under the classification system in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) from the following list:

Name of diagnosing psychiatrist or clinical psychologist: _____

Adult diagnostic categories appropriate for children and adolescents include:

- Substance-Related Disorders (303.90 – 305.90, not to include caffeine or nicotine-related disorders)
- Schizophrenia and Other Psychotic Disorders (293.81, 293.82, 295.10 – 295.90, 297.1, 297.3, 298.9)
- Mood Disorders (293.83, 296.00 – 296.90, 300.4, 301.13, 311)
- Anxiety Disorders (293.89, 300.00 – 300.02, 300.16 – 300.3, 300.7, 308.3, 309.81)
- Somatoform Disorders (300.11, 300.81)
- Sexual and Gender Identity Disorders (302.2 – 302.6, 302.85, 302.89, 302.9)
- Impulse-Control Disorders (312.30, 312.33, 312.34)
- Adjustment Disorders (309.0, 309.24 – 309.4, 309.9)
- Personality Disorders (coded on Axis II: 301.0, 301.20 – 301.9)

Disorders usually first diagnosed in infancy, childhood, or adolescence include:

- Pervasive Developmental Disorders (299.00, 299.10, 299.80)
- Attention-Deficit and Disruptive Behavior Disorders (312.8, 312.9, 313.81, 314.00 – 314.9)
- Tic Disorders (307.20, 307.22, 307.23)
- Feeding and Eating Disorders (307.1, 307.51, 307.52, 307.53, 307.59)
- Other Disorders of Infancy, Childhood, or Adolescence (307.3, 309.21, 313.23, 313.89)

3. The child/adolescent shows either A. Symptoms or B. Functional Impairments.

A. Symptoms – the child/adolescent must have one of the following

- Psychotic symptoms – serious mental illness (e.g. schizophrenia)

characterized by defective of lost contact with reality, often with hallucinations or delusions.

___ Danger to self, others and property as a result of emotional disturbance. The individual is self destructive, e.g., at risk for suicide, runaway, promiscuity, and/or at risk for causing injury to persons or significant damage to property.

Handbook, Sec 4, p. 7

B. Functional Impairment in two of the following capacities (compared with expected developmental level):

___ Functioning in self care – Impairment in self care is manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes, and meeting of nutritional needs.

___ Functioning in community – Impairment in community function is manifested by a consistent lack of age appropriate behavioral controls, decision-making, judgment and value systems which results in potential involvement or involvement in the juvenile justice system.

___ Functioning in social relationships – Impairment of social relationships is manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.

___ Functioning in the family – Impairment in family function is manifested by a pattern of significantly disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare of self or others (e.g. fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations which may result in removal from the family or its equivalent).

___ Functioning at school/work – impairment in any one of the following:

___ Impairment in functioning at school is manifested by the inability to pursue educational goals in a normal time frame – e.g. consistently failing grades, repeated truancy, expulsion, property damage or violence toward others; or Identified as having an Emotional/Behavioral Disability (EBD) under ch. PI 11 and 115.76 WI Statutes; or

___ Impairment at work is the inability to conform to work schedule, poor performance, poor relationships with supervisor and other workers, hostile behavior on the job.

4. The child/adolescent is receiving services from two or more of the following service systems: Please complete "Service Provider Information" on page 2 for each service selected.

___ Mental Health

___ Social Services

___ Child Protection Services

___ Juvenile Justice

___ Special Education

___ Alcohol & Other Drug Abuse Services

Eligibility Criteria Waived Under Certain Circumstances for Day Treatment of Intensive In-Home Psychotherapy under Health Check:

This individual would otherwise meet the definition of SED but has not yet received services from more than one system, but, in judgment of the medical consultant, would be likely to do so were the intensity of treatment requested could not be provided. Please explain:

This individual would otherwise meet the definition of SED but functional impairment has not persisted for six months but, in the judgment of the medical consultant, the nature of the acute episode is such that such

impairment in functioning (as defined in the definition of SED above) is likely to be evident without the intensity of treatment requested. Please explain: