COORDINATED CHILDREN'S SERVICES OF CLINTON COUNTY REFERAL FORM

NAME OF CHILD: _____
DOB: _____ GENDER: _____
ADDRESS OF CHILD: _____
_____
PHONE NUMBER: (HOME) _____ **(CELL)**_____

NAME OF PARENT/GUARDIAN: _____
RELATIONSHIP TO CHILD: _____
ADDRESS OF PARENT/GUARDIAN: _____
_____
RELEASE SIGNED/DATE: _____
BEST TIME & METHOD TO CONTACT FAMILY:
_____

SCHOOL DISTRICT/PLACEMENT:_____
GRADE: _____
CSE CLASSIFICATION: _____

REFERRAL SOURCE:
NAME: _____
AGENCY:_____
PHONE:_____
E-MAIL:_____

REASON FOR CCSI REFERRAL:
_____
_____
_____
_____
_____
_____

WHAT SERVICES IS THE CHILD/FAMILY CURRENTLY INVOLVED WITH?
LIST AGENCY AND EMPLOYEE
COUNSELING _____
DSS _____
PROBATION _____
OTHER _____

COMPLETED REFERRALS SHOULD BE MAILED/FAXED TO:
CCSI Coordinator, CCMHAS, 130 Arizona Ave., Suite 1500, Plattsburgh, NY 12903
FAX: 518-566-0168

For Office Use Only:
Received: _____
Decision: _____
FIT Notified: _____

CLINTON COUNTY
COORDINATED CHILDREN'S SERVICES INITIATIVE
CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Name of Child:
Address of Child:
Name of Parent Signing Consent:
School District /School Attending/Grade:
Name of County or City of New York: Clinton County
Issuing Office: Clinton County Mental Health and Addiction Services
Address, Telephone Number of Issuing Office: 130 Arizona Ave, Suite 1500 Plattsburgh, NY 12903 (518)565-4060
Starting Date of Consent: Ending Date of Consent:

PURPOSE: The Coordinated Children's Services Initiative was established to insure that families are supported in staying together, and that children remain at home and in their communities, by improving the quality of decision making for children with emotional and behavioral disturbances through State and local interagency partnerships. An essential component of the Initiative is the establishment of a local service planning team which accepts referrals, compiles assessment and referral materials, and develops, coordinates and implements individualized service plans for children and their families.

I understand that it may be necessary for the members of the team to exchange confidential information relating to my child, myself and our family and to obtain information from other individuals, organizations and agencies that have provided services to my child and our family in order to develop appropriate service plans. The purpose of this form is to obtain informed consent for the disclosure of confidential information necessary to address the needs of my child and our family.

GENERAL CONSENT: I hereby consent to the disclosure of confidential information relating to my child in order to allow my child to participate in the Coordinated Children's Services Initiative. Information may be requested from the agencies, organizations and individuals identified in the Consent as Information Sources and may be provided to Coordinated Children's Services Initiative team members and others identified in this Consent as Information Recipients.

As the parent and caretaker of the child, I also consent to the disclosure of confidential information relating to me from the identified agencies, organizations and individuals, in order to allow my participation in the Coordinated Children's Services Initiative.

I understand I may ask any questions or make any comments about this Consent to the Issuing Office identified above. I also understand that I may revoke this consent at any time by contacting the Issuing Office in person, by telephone or in writing and may change any part of this Consent at any time by sending or delivering a signed Consent, with the changes, to the Issuing Office. However, any disclosures of information made by the identified Information Sources before a change or revocation remain valid even though the disclosure would not be permitted after the change or revocation. In addition, any disclosures made by the identified Information Sources after the change or revocation in order to pay, account or claim for reimbursement for, or to evaluate, services provided before the change or revocation will be valid under this Consent. Neither the signing of this Consent nor the revocation of this Consent should be construed to restrict the right of any person to disclose information as otherwise authorized or required by law or regulation regardless of consent.

Information which is disclosed pursuant to this Consent will be kept confidential by the Information Recipients, will not be redisclosed to any other person, agency or organization by the Information Recipients, and will not become part of the internal records of the government agencies represented on the Coordinated Children's Services Initiative team.

I understand that I am not required to consent to the disclosure of any information. My failure or refusal to consent to the disclosure of information will not result in any denial or reduction of services required to be made available to my child or family. However, because the lack of access to records by the members of the Coordinated Children's Services Initiative team may result in incorrect assessment results and the approval of inappropriate or unnecessary services, the team may elect to not work with my child or family if I decide to withhold consent to the release of necessary information.

I understand this Consent does not authorize the release of information on AIDS and HIV governed by Article 27-F of the Public Health Law.

I understand that this Consent remains in effect for one year from the date of signature, unless another Ending Date is given.

Finally, I understand that my consent to the release of information means the Information Sources will release information they maintain based on their opinion that the information is relevant to Coordinated Children's Services Initiative assessment and services, and may not result in the release of all information maintained by the Information Source.

I have read and fully understand this document and hereby give consent of my own free will to disclose any and all information deemed necessary by the Information Sources designated herein.

_____ _____ _____ _____

(Signature of Parent or Guardian) (Date) (Signature of Child) (Date)

INFORMATION SOURCES: The information identified below, to the extent it is relevant to the purposes of the Coordinated Children's Services Initiative, may be released under this consent by the following government agencies, medical professionals or facilities, or other organizations or individuals (please list any agencies, organizations or individuals that may have information relevant to the purposes of the Coordinated Children's Services Initiative and provide an address, telephone number or other means of contacting each: Using the Guide to Services and Providers or your own recollection of services that have been made available to your child or family, please list the categories of information which may be released under this consent):

Name of Information Source: See Attached Sheet
Information to be released: All Pertinent Information
(attach additional sheets as necessary)

INFORMATION RECIPIENTS: Information may be provided pursuant to this Consent to the agencies which are members of the Coordinated Children's Services Initiative, which may include representatives of the county or city department of social services, the county or city department of mental health, the local youth bureau, the school or school district attended by the child, the county or city probation department, the New York State Office of Mental Health, and the New York State Division for Youth.

In addition, information may be released to the following service providers which have been identified in the plan of services developed for my child and our family pursuant to the Coordinated Children's Services Initiative:

Name of Service Provider: See Attached Sheet
Address: See Attached Sheet
(attach additional sheets as necessary)

CONSENT TO DISCLOSURE OF ALCOHOLISM OR SUBSTANCE ABUSE TREATMENT INFORMATION:
I, _____, as the child who is the subject of a Coordinated Children's Services Initiative assessment, authorize _____ to release the following alcoholism and drug abuse treatment information to the members of the Coordinated Children's Services Initiative interagency team for the purposes set forth above (be as specific as possible; attach additional sheets as necessary):
_____
This consent will expire at the time specified in the above General Consent. I understand that my alcoholism and substance abuse treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Substance Abuse Patient Records (42 C.F.R. Part 2) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

_____ _____ _____ _____

(Signature of Child) (Date) (Signature of Parent or Guardian, if required) (Date)

PARENT/GUARDIAN MUST DATE AND INITIAL EACH AGENCY THAT APPLIES BELOW:

_____ Children's Single Point of Access (SPOA) Committee (Must be initialed & dated)
CCSI Tier II Clinical Oversight Committee
130 Arizona Ave., Suite 1500
Plattsburgh, NY 12903

_____ Clinton County Department of Social Services
13 Durkee Street
Plattsburgh, NY 12901

_____ Champlain Valley Family Center*
20 Ampersand Drive
Plattsburgh, NY 12901

_____ Champlain Valley Physicians Hospital Medical Center
75 Beekman Street
Plattsburgh, NY 12901

_____ Champlain Valley Educational Services
1585 Military Turnpike
Plattsburgh, NY 12901

_____ Clinton County Mental Health & Addiction Services*
130 Arizona Ave., Suite 1500
Plattsburgh, NY 12903

_____ Behavioral Health Services North
2155 State Route 22B
Morrisonville, NY 12962

_____ Clinton County Department of Probation
34 Court Street
Plattsburgh, NY 12901

_____ Clinton County Family Court
137 Margaret Street
Plattsburgh, NY 12901

_____ Parent Partner _____

_____ School District:_____

_____ Health Care Provider:_____

_____ Therapist/Counselor:_____

_____ Other _____

_____ Other _____

* Consent to disclosure of alcoholism or substance abuse treatment on page 2 needs to be signed