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

Date: _____

CASSP Involvement: CASSP is a voluntary process. Before completing this referral, please contact me to review expectations and confirm parental agreement. In some cases, needs can be resolved without a meeting.

Child/Adolescent Information

Name: _____ Medical Assistance (MA) ID #: _____

Preferred Name: _____ ___ Preferred Pronouns: _____

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

Address: _____

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

Primary Language: _____

Does a translator need to be provided? 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 (e.g., *Primary caregiver, Shared custody, Limited involvement*):

_____

Parent/Guardian: _____ Phone: _____

Address: _____

Email: _____ Best way to contact: _____

Parent/Guardian's level of involvement (e.g., *Primary caregiver, Shared custody, Limited involvement*):

_____

Is there a current custody agreement/court order? Yes ☐ No ☐

Please note providers will require consent from all parties who have legal custody of child.

Additional Members Residing in Household:

Name	Relationship	Age	Phone Number

What is the reason for this CASSP Referral? (Check all that apply)

- ☐ Need for Team Planning *(Coordinating Multiple Services)*
- ☐ Consideration of out-of-home placement
- ☐ Behavior/Exacerbation of Mental Health Symptoms
- ☐ Discharge/Transition Planning
- ☐ Other: _____

Describe the challenges/behaviors of the child which led to making a CASSP referral:

Current Mental Health Service Information

Mental Health Diagnosis: _____

List the current mental health treatment providers involved with the child and family (e.g., *Outpatient therapy, IBHS, Family Based, Medication Management, etc.*):

Service Type/Provider	Contact Person

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

_____

_____

_____

_____

Please include a recent evaluation and/or treatment plan.

Other Agency Involvement

Please indicate if the child/adolescent receives any of the following services (check all that apply):

- Children and Youth Services (CYS or FCSFC) ☐ Contact: _____
- Juvenile Probation ☐ Contact: _____
- MH Case Management ☐ Contact: _____
- IDD Supports Coordination ☐ Contact: _____

School information

School District: _____ Grade: _____

Contact Person: _____ Title: _____

Phone: _____ Email: _____

Does the child receive any of the following (check all that apply):

☐ 504 Plan ☐ Individualized Education Plan (IEP)

☐ Emotional Support ☐ Learning Support ☐ Autistic Support ☐ Life Skills ☐ 1:1 Aide

☐ Speech Therapy ☐ Occupational Therapy ☐ Physical Therapy

Please provide any additional school information and/or concerns in the school setting:

Attach IEP/504 plan if available.

Scheduling the CASSP Meeting

Please list preferred meeting days and times:

Would you prefer to meet in person or via Microsoft Teams? ☐ In Person ☐ Teams

Name of Person Completing this Form: _____

Agency: _____

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 and submitted with this referral.

For questions or secure document submission, contact Nancy Strueber at njstrueber@Franklincountypa.gov or 717-709-2307. If you do not have secure email, I can initiate a secure email chain.

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