

AUTHORIZATION FOR RELEASE OF INFORMATION FOR TFC REFERRAL

Client Name: _____ Date of Birth: _____

I request and authorize:

CCS TREATMENT TEAM (Person requesting information)
Creative Community Services, Inc.
4487 Park Drive, Suite A.
Norcross, GA 30093
Tel: (770) 469-6226 / Fax: (770) 469-6210

To obtain from and/or release information: CUSTODIAN/LEGAL GUARDIAN

Name of person: _____

Name of Agency: (if applicable) _____

Address: _____

Tel: _____ Fax: _____

Please Send All Applicable Documents:

All information included in No. 1 – 8 of checklist for staffing and permission to forward this information to potential therapeutic foster parents for placement consideration.

This document serves as an open communication release for both parties to exchange information regarding client progress and placement. I understand that this information may be sent via fax machine.

All information I authorize to be obtained from the releasing person/institution will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for:

_____ 90 days _____ 120 days _____ (specify date)

I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken which was based on my consent: I may withdraw this consent at any time.

Client Signature: _____ Date: _____

Parent/Legal Guardian: _____ Date: _____

Witness: _____ Date: _____

I withdraw my consent to the release of information: _____

Signature and date



Children and Youth Considered for Admission:

- Males and females ages 3 to 17.
- Children and youths labeled mentally ill, mentally retarded, emotionally disturbed, or autistic.
- Children and youths eligible for Medicaid or has third party insurance.
- Children and youths in custody of birth parents and/or state agency.

Children and Youth Not Appropriate for Placement with Creative Community Services:

- Children and youths who have exhibited aggressive or dangerous behaviors to self or others within the last 6 months.
- Children and youths who are chemically dependent.
- Children and youths expressing suicidal ideation and/or gestures within the last 6 months.
- Children and youths with histories of dangerous crimes (Assault, Rape, etc).
- Children and youths that are currently exhibiting fire setting behavior.
- Children and youths who are HIV positive.
- Children and youths with histories of chronic elopement behavior.
- Children and youths who are medically fragile.

Creative Community Services General Intake Protocol

1. Intake Departments follow the mission and philosophy of CCS – which is to improve the quality of life for children, adults and families who are facing special challenges through community based support and services.
2. All referrals are made to the Intake Coordinator.
3. Assessments such Social History, diagnoses, psychological, and medical status, are required during screenings process.
4. Decisions to accept or deny for services is a team process (excluding crisis respite).
5. Referred individuals must be at least age 3.
6. All intakes are individually screened, assessed and either recommended for placement or referred to another service provider.
7. All services are based on individual needs and are matched accordingly.
8. Billing information is required in writing prior to admission.
9. Timelines are developed for pre-placements, trial visits, respite and permanent placements.
10. Each case is assigned a Family Consultant or Respite Coordinator and Supervisor.

CREATIVE COMMUNITY SERVICES, INC. (CCS) THERAPEUTIC FOSTER CARE

This is the list of items that CCS needs to consider a child for TFC candidacy (to staff):

1. _____ Completed Pre-Interview Application (this document)
2. _____ Psychological Evaluation with IQ testing completed within past 2 years
3. _____ Updated Social History or 1st Placement/Best Placement Assessment
4. _____ Statement of Health/Medical Needs
5. _____ Letter/Memo Confirming Level/Funding
6. _____ Signed an Authorized for Release of Information (enclosed)
7. _____ Psycho Sexual Evaluation (if applicable)
8. _____ Current Treatment Individualized Service Plan (if applicable)

These are additional items needed to consider a child for TFC placement (to place):

9. _____ Birth Certificate
10. _____ Social Security Card
11. _____ Immunization Records
12. _____ School Records/IEP
13. _____ Eye, Ear, and Dental (DHR 300)
14. _____ Insurance/Medical History
15. _____ Dental History (within the last 6 months)
16. _____ Discharge Summaries for Previous Treatment Facilities

If applicable:

17. _____ Custody Papers
18. _____ Panel Review (most recent)
19. _____ Court Order
20. _____ Case Plan
21. _____ MATCH Profile Instrument

***NOTE:**

Items 1-8 must be submitted to the Intake Department by Wednesday at 5:00pm to be staffed on Tuesday morning with the Placement Treatment Team. Any information received after the deadline will be staffed on the following Tuesday.



Pre-Interview Application for Services

The following documents are required to apply for services prior to an interview:

1. Completed Pre-Interview Application (this document)
2. Psychological Evaluation with IQ testing completed within past 2 years
3. Updated Social History or 1st Placement /Best Placement Assessment
4. Statement of Health/Medical Needs
5. Letter/Memo Confirming Level/Funding
6. Signed an Authorized for Release of Information (enclosed)
7. Psycho Sexual Evaluation (if applicable)
8. Current Treatment Individualized Service Plan (if applicable)

Please note that items 1-8 must be submitted to the intake department by Wednesday at 5:00pm to be staffed on Tuesday morning with the Placement Treatment Team. Any information received after the deadline will be staffed on the following Tuesday.

Date of Application: _____

Child's Name: _____ Age: _____

Date of Birth: _____ Sex: _____ Race: _____

Social Security #: _____ Medicaid #: _____

Revenue Source: MAAC FRC Champs LOC/Level 3 4 5
 DJJ MHM RSA Other _____

Referring Agency/DFCS Case Manager's Name: _____

Address: _____ Telephone #: _____

_____ Fax #: _____

Email Address: _____

Legal Guardian: _____ Telephone #: _____

Email Address: _____ Emergency Tel #: _____

List other involved agencies and contact information (example: DJJ, Mental Health, Wraparound provider): _____

Current Residence/ Placement: _____

Contact Person: _____

Address: _____ Telephone #: _____

Fax #: _____

Length of time at current placement? _____

Reason for seeking new placement? _____

Educational Services:

- | | |
|--|---|
| <input type="checkbox"/> Regular Classroom | <input type="checkbox"/> Resource Classes |
| <input type="checkbox"/> EBD- Self Contained Classroom | <input type="checkbox"/> Psycho- educational Facility |
| <input type="checkbox"/> Alternative School | <input type="checkbox"/> Residential/ On- site School |

Grade Level: _____ Most recent school placement: _____

Child Strengths (Interests or Abilities):

- | | | |
|--|---|---|
| <input type="checkbox"/> Artistic | <input type="checkbox"/> Communication | <input type="checkbox"/> Friendly |
| <input type="checkbox"/> Personable | <input type="checkbox"/> Humor | <input type="checkbox"/> Affectionate |
| <input type="checkbox"/> Family Support | <input type="checkbox"/> Emotional Connection | <input type="checkbox"/> Music/Instrument |
| <input type="checkbox"/> Motivation | <input type="checkbox"/> Academics | <input type="checkbox"/> Athletics |
| <input type="checkbox"/> External/Internal Support | <input type="checkbox"/> "Street Smarts" | |

Other strengths: _____

Describe situations when child has been most successful: _____

Identified Family Participating in Treatment (include relatives, mentor, coach, former foster family, adoptive family, birth family and any others who have been approved by the child's legal guardian to participate):

Who does child identify as family of choice (please include contact info)?

Describe any cultural or religious considerations in treatment: _____

Services (within last 6 months):

- | | | |
|--|--|--|
| <input type="checkbox"/> Individual Therapy | <input type="checkbox"/> Crisis Stabilization | <input type="checkbox"/> Specialized Treatment Services |
| <input type="checkbox"/> Community Support | <input type="checkbox"/> Respite | <input type="checkbox"/> Specialized Adaptive Devices |
| <input type="checkbox"/> Special Ed Services | <input type="checkbox"/> Behavior Aide | <input type="checkbox"/> Specialized Medical / Dental Care |
| <input type="checkbox"/> Day Treatment | <input type="checkbox"/> Advocacy | <input type="checkbox"/> Medication Monitoring |
| <input type="checkbox"/> Respite Services | <input type="checkbox"/> Dedicated Cases Mgmt | <input type="checkbox"/> Birth Family/ Contact |
| <input type="checkbox"/> Family Education | <input type="checkbox"/> Family Intervention/ Family Therapy | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Mentoring/Tutoring | <input type="checkbox"/> Specialized Assessment | |

Successful Interventions:

- | | | |
|--|---|---|
| <input type="checkbox"/> Redirection | <input type="checkbox"/> Therapeutic Hold | <input type="checkbox"/> Reward/ Incentives |
| <input type="checkbox"/> Time Out | <input type="checkbox"/> Humor/ Distraction | <input type="checkbox"/> Loss of Privileges |
| <input type="checkbox"/> Behavior Plan | Other: _____ | |

Behaviors: (please indicate **C** = current in last 6 months, or by **H** = history)

- | | | |
|---|--|--|
| <input type="checkbox"/> Eating Issues | <input type="checkbox"/> Legal Involvement | <input type="checkbox"/> Mood Swings |
| <input type="checkbox"/> Lying | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Compulsive Behavior |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Defiance | <input type="checkbox"/> Substance Abuse/ Dependence |
| <input type="checkbox"/> Physical Aggression | <input type="checkbox"/> Angry/Irritable | <input type="checkbox"/> Gang Involvement |
| <input type="checkbox"/> Stealing | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Cruelty to Animals |
| <input type="checkbox"/> Enuresis | <input type="checkbox"/> Depression | <input type="checkbox"/> Bullying |
| <input type="checkbox"/> Self- Injury/Mutilation | <input type="checkbox"/> Tantrums | <input type="checkbox"/> School Issues/Concerns |
| <input type="checkbox"/> Hoarding | <input type="checkbox"/> Suicidal | <input type="checkbox"/> Psychotic Symptoms |
| <input type="checkbox"/> Encopresis | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Sexual Orientation/ Issues |
| <input type="checkbox"/> Fire Setting | <input type="checkbox"/> Hallucinations | |
| <input type="checkbox"/> Runaway | <input type="checkbox"/> Inattention | |
| <input type="checkbox"/> Sexual Behaviors Offender/Victim | <input type="checkbox"/> Promiscuous | |
| | <input type="checkbox"/> Prostitution | |

Explain all behaviors checked above: _____

DSM Diagnosis (please include diagnostic code):

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Full Scale IQ _____ Verbal _____ Perf. _____ Date of Test _____ Type of Test _____

Current Medications: _____

Allergies/Physical/Medical Conditions: _____

Does child require assistance with personal care chores? _____
_____ Toileting _____ Bathing _____ Grooming _____ Dressing

Describe other Assistance Needed: _____

Please explain why TFC is the most appropriate placement for this child as opposed to other treatment options: _____

Attach a full placement history **OR** complete below:

Dates of Placement	Placement	Reason for Leaving

Please check all that apply:

Cross- cultural placement is appropriate _____ **OR** Race- specific placement is required _____
Can reside with single parent _____ **OR** Two- parent home is required _____
Can reside with other children _____ **OR** Needs home with no other children _____
Can reside with younger children _____
Can reside with older children _____

Any other special requirements regarding type of home: _____

In your opinion, what would be the "ideal" family that would most appropriately meet this child's needs? _____

How does the child feel about going into a TFC family? (please specify) _____

What is the plan for visitation and/or reunification once the child is placed?

Would it be necessary for the child to be placed in close proximity to his/her family? If so, where?

How does the family feel about the child going into a TFC home? _____

Any other comments/information: _____

CREATIVE COMMUNITY SERVICES, INC.

4487 Park Drive, Suite A.
Norcross, GA 30093

PRIVACY POLICY

Effective: April 14, 2003

We understand that medical information is personal. We are committed to maintaining the privacy of your protected health information, which includes your health condition and the treatment you receive from CCS.

You have a record which is used to provide you with quality care and with certain legal requirements. At the time you begin to receive services and at any time there are changes in our maintenance of this record, you will be notified and requested to sign that you understand our services and protection.

We are required to abide by the terms of the Notice of Privacy Practices. You can obtain a copy of this form and have conversation regarding its implications by contacting the Creative Community Services Privacy Officer, Sheila Dean, at this office or e-mail at sdean@ccsgeorgia.org.