

Vermont Department of Education and
Agency of Human Services
Interagency Agreement

Section 1:
Coordinated Service Plan (CSP)
Forms

Version: April 9, 2009

For a CSP → Complete Section 1

For referrals to LIT or SIT → Complete Sections 1 & 2

For referrals to CRC → Complete Sections 1, 2, & 3

1. Coordinated Service Plan Overview

“A **Coordinated Services Plan** is a written addendum to each service plan developed by an individual agency for a child or adolescent with severe emotional disturbance which shall be developed when the eligible child has needs that require services from more than one agency. It shall be designed to meet the needs of the child within his or her family or in an out-of-home placement, and in the school and the community.” (Act 264, revised, 1989)

In 2005, an additional **Interagency Agreement** was developed in which “eligible children and youth are entitled to receive a coordinated services plan

developed by a service coordination team including representatives of education, the appropriate departments of the Agency of Human Services, the parents or guardians, and natural supports connected to the family. The coordinated services plan includes the Individual Education Plans (IEP) as well as human services treatment plans or individual plans of support, and is organized to assure that all components are working toward compatible goals, progress is monitored, and resources are being used effectively to achieve the desired result for the child and family. Funding for each element of the plan is identified.” (Interagency Agreement, 2005)

PLEASE NOTE: Coordination of services provides coordination of planning **but not** entitlement for specific services. Approval for specific services and/or placements is the responsibility of the appropriately involved agency or agencies. Established approval processes must be followed in implementing components of this plan.

Factors to Consider in Developing a Coordinated Services Plan

- 1. Are the parents, guardians, and /or educational surrogate parents, on the team?**
 - Other family members or friends on the team? Can the child/youth participate?
 - Are there representatives from the appropriate agencies such as community mental health, local education agency, and Agency of Human Services Divisions and Programs?
- 2. What are the goals of the plan?**
 - What are the child/youth, family, and other treatment team members' goals?
 - Do the recommended supports and services help to achieve those goals? *Goals should not be a list of services*, rather what is hoped to be attained with supports and services.
 - Is the CSP team (including the family) in agreement?
- 3. What are the strengths of the child and family?**
 - How is the child successful? What are the child's interests?
 - What natural supports and resources are available to the child?
 - What are the strengths of the family?
- 4. What are the needs of the child and family?**
 - What are the areas of concern and need? (What are the clinical concerns?)
 - What other stressors are impacting the child and the family?
- 5. Are there current written assessments? What was the purpose of the assessments?**
 - Does the assessment include the family?
 - Does the assessment include strengths of the individual and the family?
 - Were the evaluators familiar with local resources?
- Have past evaluations been reviewed and recommendations implemented?
 - What level of risk exists?
 - Is the child on an IEP?
 - Has medication been considered and for what purpose?
- 6. What local services have been tried?**
 - For how long, and what were the results?
 - Did community-based services actively involve the parents?
 - If the results were not positive at that time, what do CSP team members believe were the reasons? Can these reasons be reduced/eliminated sufficiently to significantly improve the prospect for success?
 - Who has participated in supports, and in treatment or services?
 - What less restrictive interventions have been tried? If less restrictive interventions have been ruled out, explain why. (*It is important to note that our system of care supports serving the child in the least restrictive manner appropriate to the child/youth's well-being.*)
- 7. What is the local CSP team recommending?**
 - What are the CSP team recommendations? Is the team in agreement?
 - What will constitute a successful outcome? How are the recommendations related to the stated need?
- 8. How will the team be accountable?**
 - When will the team next meet to determine if the plan has been implemented?
 - Since a change for the better is expected, how will the team determine if it is happening?
 - What indicators will measure progress?

2. Consent for Eligibility Determination & Coordinated Services Planning

Child/Youth's Name	Lead Agency
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A Coordinated Services Plan (CSP) is a process that follows a series of steps to help children and youth realize their hopes and goals. People from the child or youth's life work as a team to develop a plan that brings together the services and supports needed. I understand that as a parent I am a member of the CSP team.

I give my consent to the lead agency to start the process of determining if my child is eligible for a CSP. Often eligibility is part of the initial CSP meeting when information is gathered and reviewed about how particular agencies or departments are involved with the child/youth.

If my child is eligible, I give consent for the CSP team to develop a coordinated services plan.

I understand that:

- I must also sign a *Consent for Release of Information* form (page 3). The *Consent for Release of Information* will let the lead agency share my child's information with the CSP team. The CSP team members are listed on page 4.
- The lead agency will let me know within 30 days of when it gets this signed form and the signed *Consent for Release of Information* whether or not my child is eligible.
- Records that the lead agency has gathered throughout the coordinated services planning process are confidential. The lead agency will not share these records with others without first getting my consent in writing unless the law says they must be shared.
- I can look at or get a copy of these records by writing a letter to the lead agency.
- I will be given a copy of this consent form after I sign it.
- If I do not give my consent the lead agency cannot determine if my child is eligible for a CSP and a CSP cannot be developed.
- My child's current benefits and services will not be affected if I do not give my consent.

If my child is found eligible, I want to speak with my Local Interagency Team's parent representative before the <i>Coordinated Services Plan</i> meeting.	<input type="checkbox"/> Yes <input type="checkbox"/> No
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	Print Name	Signature	Date
Parent / Guardian			
Witness			
Educational Surrogate Parent (<i>if applicable</i>)			

3. Consent for Release of Information

Child/Youth's Name	Lead Agency
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I consent to the sharing of information about my child to the Coordinated Services Planning Team (CSP team). The CSP team members are listed on page 4. I understand that as a parent I am a member of the CSP team.

I understand that:

- My child's information includes records of educational, psychological, social history, medical evaluations, and services given to my child.
- My child's information will be shared with the CSP team so that the team can determine if my child is eligible for a CSP and if so, develop and implement a CSP for my child.
- I can look at or get a copy of the information about my child that is shared with CSP team by writing a letter to the lead agency.
- The CSP team knows that my child's information is confidential. The team will not share information about my child with others without first getting my consent in writing unless the law says it must be shared.
- This consent form expires one year from the date that I sign it.
- I can take away my consent at any time by writing a letter to the lead agency, except for when the CSP team has already used the information.
- If I do not give my consent, the CSP team cannot determine if my child is eligible for a CSP and my child will not get a CSP.
- My child's current benefits and services will not be affected if I do not give my consent.
- I will be given a copy of this consent form after I sign it.
- General information about the usefulness of the coordinated services planning process is gathered by the State Interagency Team. Information from my child's CSP may be used in this effort, but information on my child and family will not be identified.

I want to speak with my Local Interagency Team's parent representative.	<input type="checkbox"/> Yes <input type="checkbox"/> No
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	Print Name	Signature	Date
Parent / Guardian			
Witness			
Educational Surrogate Parent (if applicable)			

7. Elements of a Coordinated Services Plan

A. What are the hopes and goals for this child or youth?

(Family voice and choice is an important value of the coordinated services planning process.

Please make sure that the child or youth and family members have an opportunity to speak first.)

B. What are the family and child/youth's strengths, resources, and natural supports that can help realize those hopes and goals?

(Natural supports include family members' networks of relationships and community resources.)

C. What are the needs, challenges, concerns, and priorities that must be considered?

(Use existing plans and assessments as well as current experience to identify these.)

7. Elements of a Coordinated Services Plan (cont.)

D. What are the current supports and services that help realize those hopes and goals?

Support / service	Responsible party	Current status & funding

E. What is the proposed plan of supports and services? (Consider how these address the needs in 7C.)

Support / service	Responsible party	Date to begin	Current status & funding

Date of CSP review (no more than one year from date of current plan):

8. Elements of a Proactive Crisis Plan

Use this section only if needed and/or attach existing agreed upon behavior plans or support documents that address this need across environments.

Teams are strongly encouraged to develop a proactive crisis plan if the child or youth is medically fragile, at risk for, or has ever been hospitalized in a psychiatric setting, or demonstrates risky and unsafe behaviors.

Situation (triggers/stressors)

Coping strategies (Describe skills, strategies, to prevent, reduce or de-escalate crisis)

What is needed to feel safe in crisis?

Key support people to contact – include names, relationship and contact information.

What to do to manage the crisis?

What NOT to do

Conditions for emergency room, police, hospital

PLEASE NOTE: *There may be special or unusual circumstances that will require the responsible adults to modify the plan.*

9. Appeal Process

Most Coordinated Services Planning Teams are able to write and successfully implement a child or youth's Coordinated Service Plan. At times, a **team** may need to turn to its Local Interagency Team (LIT) for technical assistance, consultation or dispute resolution. Occasionally, a **LIT** may need to turn to the State Interagency Team (SIT) for technical assistance, consultation or dispute resolution. **Parents**, as members of a Coordinated Services Planning Team, may turn to the LIT or SIT for dispute resolution.

PLEASE NOTE: *If a parent has a dispute regarding **service delivery** rather than **service coordination** s/he must use the appropriate dispute resolution mechanism(s) in the section C. below.)*

A. Act 264 Appeal Process Regarding Coordination of Services

A local agency, a service provider or a parent on the team may request an appeal concerning coordination among the agencies under Act 264 and related provisions of the Interagency Agreement.

An appeal is available if the State Interagency Team is unable to resolve the dispute. The SIT shall inform the local agency, service provider(s) and parent(s) of their right to an appeal and provide the name and address for submitting the appeal.

The appeal process shall consist of a hearing pursuant to Chapter 25 of Title 33. The hearing shall be conducted by a hearing officer appointed by the Secretary of the Agency of Human Services and the Commissioner of Education. Based on evidence presented at the hearing, the hearing officer shall issue written findings and proposals for decision to the Secretary and the Commissioner. The Secretary and the Commissioner may affirm, reverse, or modify the proposals for decision. All parties shall receive a written final decision of the Secretary and the Commissioner.

B. Appeal Process Regarding Issues of Payment and Reimbursement between Agencies

When a non-education agency fails to provide or pay for services for which they are responsible and which are also considered special education and related services, the school district (or state agency responsible for developing the child's Individualized Education Plan [IEP]) shall provide or pay for these services to the child in a timely manner. The school district (or state agency responsible as the education agency) may then claim reimbursement for the services from the non-education agency that was responsible and failed to provide or pay for these services. The procedures outlined in the Interagency Agreement of June 2005 shall be used for reimbursement claims between agencies.

C. Other Grievance Procedures Available to Parents.

In addition to the opportunity to file an appeal regarding coordination of services under Act 264, the parent has the right to other grievance procedures depending on the nature of the service and complaint. Those grievance procedures may include but are not limited to:

- 1) Parent's complaints regarding the provision of a free appropriate public education and other rights under the Individuals with Disabilities in Education Act: contact the Department of Education at (802) 828-3136.
- 2) Managed Care Organization grievance related to Medicaid Coverage: contact the Office of Vermont Health Access at 879-5900.
- 3) Grievances related to Medicaid Eligibility: contact the Department for Children and Families, Economic Services Division at 241-2800.
- 4) Complaints or grievances regarding staff performance or quality of programs: contact the supervising provider responsible for service delivery.

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Section 2:
LIT, SIT or CRC Referral Forms

Version: April 9, 2009

For a CSP → Complete Section 1

For referrals to LIT or SIT → Complete Sections 1 & 2

For referrals to CRC → Complete Sections 1, 2, & 3

*Forms Being Submitted To
(please check all that apply) :*

- Local Interagency Team (LIT)
- State Interagency Team (SIT)
- Case Review Committee (CRC)

1. Release of Information for Interagency Team Review of Coordinated Services Plan

Child/Youth's Name	Lead Agency
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Most Coordinated Services Plans (CSPs) get carried out. If, however, a CSP team does not agree with a plan, they may call upon the Local Interagency Team (LIT) for help. If the LIT cannot create a plan that everyone agrees with, the State Interagency Team (SIT) may be asked for help. If a CSP Team is thinking about wrap-around or residential care, then the CSP Team must ask the Case Review Committee (CRC) to review and consider this possibility.

I give my consent for the release of pertinent information including the Coordinated Services Plan (CSP) to the: Local Interagency Team (LIT), State Interagency Team (SIT), and/or Case Review Committee (CRC).

I understand that:

- My child's information includes records of educational, psychological, social history, medical evaluations, and services given to my child. My child's information also includes his or her CSP.
- My child's information will be shared with LIT, SIT, and/or CRC so that they can (1) review my child's CSP or (2) review the request for intensive wrap-around or residential care.
- I can look at or get a copy of the information about my child that is shared with LIT, SIT, and/or CRC by writing a letter to the lead agency.
- Members of LIT, SIT, and/or CRC know that my child's information is confidential they will not share information about my child with others without first getting my consent in writing unless the law says they must be shared.
- This consent form expires one year from the date that I sign it.
- I can take away my consent at any time by writing a letter to the lead agency, except for when LIT, SIT, or CRC has already used the information.
- If I do not give my consent, LIT, SIT, and/or CRC cannot (1) review my child's CSP or (2) review the request for intensive wrap-around or residential care.
- My child's current benefits and services will not be affected if I do not give my consent.
- I will be given a copy of this consent form after I sign it.
- General information about the usefulness of the coordinated services planning process is gathered by the State Interagency Team. Information from my child's referral documents may be used in this effort, but information on my child and family will not be identified.

I want to speak with my Local or State Interagency Team's parent representative before the LIT, SIT, or CRC meeting.	<input type="checkbox"/> Yes <input type="checkbox"/> No
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	Print Name	Signature	Date
Parent / Guardian			
Witness			
Educational Surrogate Parent (if applicable)			

Child/Youth's Name: _____

2. Reason for Referral

Contact for Referral:	Phone:
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CSP and Referral Dates	CSP:	LIT:	SIT:	CRC:
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A. What is the reason for referral to LIT/SIT/CRC? (Attach documents including assessments, discharge summaries, service or treatment plans that support and provide information about the referral.)

B. What gains are hoped for by this referral to LIT/SIT/CRC?

3. Youth's Living Situation

Please check the appropriate boxes to indicate the youth's previous, current, and proposed living situations and placements. Then use the box provided below to describe the youth's proposed living situation (including name of program if applicable).

Type (check all that apply)	Previous	Current	Proposed
Independent Living	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Two Caregivers (at least one biological)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
One Biological Parent Only (without partner)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shared Parenting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adoptive Home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relatives/Unpaid Adult	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foster Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Therapeutic Foster Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Group Home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency Shelter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Residential Treatment Program Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Residential Treatment - Long-term (non drug/alcohol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug/Alcohol Residential Treatment Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical Hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Secure Juvenile Facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Correctional Facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Detention Alternatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No Place to Stay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (describe):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (describe):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (describe):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please describe proposed living situation:

4. Youth's Educational Situation

School Attending:		School where parent(s) reside:	
District:	Grade:	Contact (name & role):	Phone:

A. Special Education Status

<input type="checkbox"/> eligible; on IEP	<input type="checkbox"/> need to refer	<input type="checkbox"/> not applicable	
<input type="checkbox"/> eligible; IEP pending	<input type="checkbox"/> assessed; found ineligible		
Disability category:	Primary	Secondary	Other
If 16 years old or older, is transition plan included in IEP? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Special Education Admin:		Phone:	

B. Section 504 Status

<input type="checkbox"/> eligible; on 504 plan	<input type="checkbox"/> need to refer	<input type="checkbox"/> not applicable
<input type="checkbox"/> eligible; 504 plan pending	<input type="checkbox"/> assessed; found ineligible	
504 Coordinator:		Phone:

C. Educational Support Team Status

<input type="checkbox"/> EST plan in place	<input type="checkbox"/> need to refer	<input type="checkbox"/> not applicable
EST Coordinator:		Phone:

D. Educational Placement: *Check the boxes to indicate previous, current, & proposed educational placements.*

Kind of Placement (<i>check all that apply</i>)	Previous	Current	Proposed
Regular Classroom or child care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Regular Classroom + in-class support and/or accommodations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Regular Classroom + specialized instruction or other supports outside regular classroom (may include school-based EEE, Headstart)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Separate Classroom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alternative School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Day Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tutorial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Residential School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home and/or Hospital-based Instruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not in school - graduated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not in school - obtained General Educational Development (GED)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not in school - dropped out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not in school - suspended	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not in school - expelled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (<i>describe</i>):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please describe proposed educational placement:

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5. Services and Agencies

Services	Agency (if known)	Previous	Current	Proposed
Child Care Services		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After School Program		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mentoring		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Psychological Assessment		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavior Support Services		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Case Management / Service Coordination		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respite Services		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School-Based Clinician		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Counseling		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Group Counseling		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individual Psychotherapy		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intensive Family Based Services		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home-based Parenting Support Services		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent Counseling		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication (Psychiatric)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community Skills Training		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse Treatment		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vocational / Employment Services		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children's Personal Care Services		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Tech Nursing Services		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traumatic Brain Injury Services		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post Adoption Services		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blind / Visually Impaired Services		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deaf / Hard of Hearing Services		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (describe):		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (describe):		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (describe):		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Behavioral and Mental Health Information

Note: This section is **REQUIRED** if child or youth has an **emotional disability** under the Act 264 definition, including, but not limited to, meeting the special education regulations for an emotional disability. If this does not apply, indicate NA and go on to the next page.

A. Mental Health Status

DSM-IV Diagnosis	Code	Date	Provided by
1			
2			
3			
4			
Global Assessment of Functioning (GAF):			
List medications currently taken:			

B. Risk Factors (*check all that apply*):

Substantiated victim of: <input type="checkbox"/> physical abuse <input type="checkbox"/> neglect <input type="checkbox"/> sexual abuse <input type="checkbox"/> emotional abuse	
<input type="checkbox"/> Adjudicated sex offender	<input type="checkbox"/> Substantiated perpetrator of sexual abuse
<input type="checkbox"/> Other adjudication (<i>describe</i>):	<input type="checkbox"/> Other risk factors (<i>describe</i>):

C. Behavioral Issues (*Please complete the checklist below. If the referral is through the Department of Mental Health please attach a recent [within the past three months] Child Behavior Checklist [CBCL].*)

In the last year has the child or youth exhibited any of the behaviors listed below to a marked degree when compared to others in his/her age group?

<input type="checkbox"/> confused/strange ideas	<input type="checkbox"/> impulsive	<input type="checkbox"/> extreme sadness
<input type="checkbox"/> inappropriate/bizarre behavior	<input type="checkbox"/> runs away	<input type="checkbox"/> anxiety
<input type="checkbox"/> inappropriate emotional reactions	<input type="checkbox"/> anti-social acts	<input type="checkbox"/> maladaptive dependence
<input type="checkbox"/> inappropriate attention	<input type="checkbox"/> fire setting/fire play	<input type="checkbox"/> somatic complaints
<input type="checkbox"/> hyperactivity	<input type="checkbox"/> refusal to accept limits	<input type="checkbox"/> bladder/bowel difficulties
<input type="checkbox"/> verbal aggression	<input type="checkbox"/> self-injurious behavior	<input type="checkbox"/> persistent school refusal
<input type="checkbox"/> aggression towards people	<input type="checkbox"/> suicidal thoughts	<input type="checkbox"/> school suspension
<input type="checkbox"/> aggression towards property	<input type="checkbox"/> suicidal behavior	<input type="checkbox"/> avoidance of social contact
<input type="checkbox"/> inappropriate sexual activity	<input type="checkbox"/> stealing	<input type="checkbox"/> serious sleep disturbance
<input type="checkbox"/> extreme withdrawal from family	<input type="checkbox"/> animal cruelty	<input type="checkbox"/> problems with the law
<input type="checkbox"/> substance abuse	<input type="checkbox"/> eating disorder	<input type="checkbox"/> experienced trauma

other (*describe*):

Feel free to expand upon the above behavioral issues and the settings in which they occur:

7. Additional Information

A. Adoption Status

Is youth adopted? <input type="checkbox"/> No <input type="checkbox"/> Pending <input type="checkbox"/> Yes
<i>If yes, is there an adoption subsidy?</i> <input type="checkbox"/> No <input type="checkbox"/> Yes, <i>If yes amount \$</i>
<i>If applying for residential treatment, does the DCF Adoption Unit know the family is applying for residential treatment?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(It is the family's responsibility to notify the Adoption Unit of such a change in residence for the child/youth)</i>

B. Custody Status

Is youth in DCF custody? <input type="checkbox"/> No <input type="checkbox"/> Yes
<i>If yes, what is the custody status?</i>
Is the youth Title IV-E eligible? <input type="checkbox"/> No <input type="checkbox"/> Yes
Parent(s)'s town of residence at time of custody:
Have parental rights been terminated (TPR)? <input type="checkbox"/> No <input type="checkbox"/> Yes
<i>If yes, Parents' town of residence at time of TPR:</i>

C. Legal Status

Does youth have contact with legal system? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Guardian Ad Litem	Attorney	Probation Officer

D. Health Insurance and Supplemental Security Income

Does youth have health insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes
<i>If yes, what insurance?</i>
<input type="checkbox"/> Medicaid - <i>Type if known:</i> <input type="checkbox"/> Private - <i>Name if known:</i>
<i>Please attach a copy of the medical insurance card(s). Without a copy of the medical insurance card(s), this referral may be delayed.</i>
Does the child/youth receive Supplemental Security Income (SSI)? <input type="checkbox"/> No <input type="checkbox"/> Pending
<input type="checkbox"/> Yes, <i>If yes, SSI amount: \$</i>

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Interagency Agreement

Section 3:
Case Review Committee (CRC)
Referral Forms

Version: April 9, 2009

For a CSP	➔	Complete Section 1
For referrals to LIT or SIT	➔	Complete Sections 1 & 2
For referrals to CRC	➔	Complete Sections 1, 2, & 3

1. Coordinated Services Plan Reintegration Team

Education

Name	School District	
Address		Phone

Community Service (AHS Division / Community Mental Health)

Name	Agency / Program	
Address		Phone

Community Service (AHS Division / Community Mental Health)

Name	Agency / Program	
Address		Phone

Community Service (AHS Division / Community Mental Health)

Name	Agency / Program	
Address		Phone

2. Team Questions for Residential Referral

Please review factors to consider in *Developing a CSP* (section 1) when completing the following questions.

The *Team Cover Letter* should summarize responses on pages 2 and 3 in order to address what the team has attempted including the services history, where you are now, where you want to go, and where you see the child/youth after placement.

On the following pages, please summarize critical events of the child/youth's life situation that impact the decision to pursue residential assessment or treatment.

2. Team Questions for Residential Referral (cont.)

A. What are the barriers that prevent the needs of the child or youth from being met in a community based setting?

B. In referring for an assessment, what are the clinical and/or educational questions you wish to have answered?

C. If referring for residential treatment what are the goals of this level of intensive intervention? What are the goals of the child/youth and family?

2. Team Questions for Residential Referral (cont.)

D. What will parent/family involvement look like during out of home treatment? Are there barriers to active parent involvement? Are there recommendations for services in the home while the child or youth is receiving out of home treatment?

E. How will the team know when there is progress? What are the outcomes that you are looking for?

F. What is the discharge/community re-integration plan?

3. Interagency Referral Checklist

Referral going to:

- Case Review Committee/Residential Review Team
- Local Interagency Team (*please specify*):
- State Interagency Team
- Placement provider or agency (*please specify*):

Have you included in your mailing the following items?

- Release of Information For Interagency Team Review (Section 2, page1)
- Indication that parents accept/decline right to speak with a Local Interagency Team parent representative (Section 2, page 1)
- Coordinated Services Plan including local planning documentation (Section 1) and LIT/SIT/CRC Referral (Section 2)
- Interagency Referral Checklist (this page)
- Cover letter with summary of specific issue(s) to be addressed (Section 3, pages 2 & 3)
- Residential referral signature page (Section 3, page 5)
- Psychological evaluation report and/or other pertinent information with current social/emotional/behavioral and intellectual ability
- If the referral is through the Department of Mental Health please attach a recent (within the past three months) Child Behavior Checklist (CBCL).
- Educational evaluation report on eligibility determination, academic achievement, basic skills and functional life skills and vocational skills, as relevant
- Current Individual Education Plan (IEP), and most recent comprehensive evaluation
- Relevant medical records, including medication history
- Discharge summaries of previous placements
- If in DCF custody: most recent Disposition Report, case plan and the DCF 201R (4E Eligibility Form copy)

Copies of this packet will be sent to:

Name	Title

4. Residential Referral Agency Signature Page

PLEASE NOTE:

- If the plan calls for a residential placement and the child is on an IEP, the Special Education Director is required to sign.
- If the child is not on an IEP (i.e., child is on a 504 plan, EST plan, or in regular education) either the Principal or Special Education Director signature is required (as determined by local procedures).
- If the child/youth is in custody of the commissioner of the Department for Children and Families, the signature of the Family Services District Director is required.
- The Community Mental Health Center's Children's Director or designee signature is required.

Signature of Educational Administrator (please indicate role):

Name & Role	Signature	Phone	Residential Referral	
			Agree	Disagree
			<input type="checkbox"/>	<input type="checkbox"/>

Signature of the Division of Family Services District Director:

Name	Signature	Phone	Residential Referral	
			Agree	Disagree
			<input type="checkbox"/>	<input type="checkbox"/>

Signature of Community Mental Health Children's Director or Designated Manager:

Name	Signature	Phone	Residential Referral	
			Agree	Disagree
			<input type="checkbox"/>	<input type="checkbox"/>

Signatures of Other Team Members:

Name	Signature	Phone	Residential Referral	
			Agree	Disagree
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>