COORDINATED SERVICES PLAN (CSP)

Agency of Human Services & Agency of Education

REVISED JANUARY 2022

IMPORTANT NOTE: *This CSP process entitles families to the coordination of services, not 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.*

Table of Contents

Child/Youth's Name: _____

Coordinated Services Plan Guidance

For use by the team and facilitator.

For additional guidance about CSPs please see the Facilitator's Guide that can be found at:

https://ifs.vermont.gov/docs/sit

What is a Coordinated Services Plan?

A ***Coordinated Services Plan*** is a written plan developed by a team for a child/youth who requires services from more than one agency. It is 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. *(Adapted from Act 264 statutory language)*

In 2005, an additional ***Interagency Agreement*** was created which expanded Act 264. This agreement states that "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.

Child/Youth's Name: _____

CSP Checklist for Facilitator(s)

I. What is needed for a CSP?

- ☐ Have parent/guardian sign consent for eligibility determination
- ☐ Have parent/guardian sign release of information
- ☐ Explain what a Parent Representative is and ask if the parent is interested in hearing from the one that supports your region
- ☐ Fill out all CSP sections up to the Supplemental Section for Residential Referrals
- ☐ Provide family a copy of the CSP at the end of the meeting or in a timely manner
- ☐ Provide family the appeals process

II. What is needed for a referral to the Local Interagency Team?

- ☐ Forward the parent/guardian signed consent for eligibility determination
- ☐ Forward parent/guardian signed release for Interagency Team Review
- ☐ Explain what a Parent Representative is and ask if the parent is interested in hearing from the one that supports your region
- ☐ Ensure key people from LIT will be at the meeting AND be sure that there are not so many professionals that the meeting is overwhelming to the family
- ☐ A CSP that was completed in a team meeting

III. What is needed for a referral to the Case Review Committee?

- ☐ Forward parent/guardian sign consent for eligibility determination
- ☐ Forward parent/guardian sign release of information for Interagency Team Review
- ☐ Documentation of Authority for Medical and Educational Decision-Making -- for children/youth not in DCF custody, the packet must include documentation of who has authority for medical and educational decision-making. This can be provided through both parents signing the CSP, or documentation of sole decision-making authority from court approved custody orders, divorce agreements, or adoption orders.
- ☐ Cover letter for CRC representative with a comprehensive summary of the situation (what has worked and what hasn't), services provided, and what are the teams' goals and expectations of a higher level of treatment.
- ☐ Explain what a parent rep is and ask if the parent is interested in hearing from the one that supports their region
- ☐ Send CSP **AND** the supplemental section for residential referrals
- ☐ Residential Referral Signature page
- ☐ CANS Assessment completed within the past 3 months (full score sheet required)
- ☐ Evaluations and assessments such as psychological or psychiatric
- ☐ Current IEP, 504 or EST Plan if applicable
- ☐ Relevant medical records, including medication list
- ☐ Discharge summaries of previous placements
- ☐ If in DCF custody, most recent disposition, case plan and IV-E eligibility (DCF 201R)
- ☐ Copy of Medicaid Card OR Medicaid Number
- ☐ Documentation from private insurance that residential treatment is not covered by their insurance coverage.
- ☐ Identify the agency which will be making the referral to CRC

IV. What is needed for a referral to the State Interagency Team?

- ☐ Forward parent/guardian signed consent for eligibility determination
- ☐ Forward parent/guardian signed release of information for interagency team review
- ☐ Explain what a Parent Representative is and ask if the parent is interested in hearing from the Parent Representative who is a SIT member
- ☐ Provide the parent/guardian with the SIT Family Guide
- ☐ Cover letter for SIT Coordinator with a summary of the situation and what questions the Local Interagency Team would like SIT to answer
- ☐ Completed CSP up to the supplemental section of the CSP packet

Child/Youth's Name: _____

Consent for Eligibility Determination and Coordinated Services Planning

Child/Youth's Name	Facilitator

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 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. The *Consent for Release of Information* will let the facilitator share my child's information with the CSP team.
- The facilitator will let me know within 30 days of getting this signed form and the signed *Consent for Release of Information* whether or not my child is eligible.
- Records that the facilitator gathers throughout the coordinated services planning process are confidential. The facilitator 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 facilitator.
- I will be given a copy of this consent form after I sign it.
- If I do not give my consent the facilitator 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.

	Print Name	Signature	Date
Parent / Guardian			
Witness			
Educational Surrogate Parent (*if applicable*)			

Child/Youth's Name: _____

Consent for Release of Information

Child/Youth's Name	Facilitator

I consent to the sharing of information about my child to the Coordinated Services Planning Team (CSP team). 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, and my child's primary care provider, 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 facilitator.
- 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.
- I can take away my consent at any time by writing a letter to the facilitator, 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.

THIS CONSENT FORM EXPIRES ONE YEAR FROM THE DATE THAT I SIGN IT.

I want to speak with my Local Interagency Team's parent representative before the Coordinated Services Plan meeting. **To find out more information about Act 264 and Coordinated Services Planning you can go to www.act264.vt.gov**	☐ **Yes** ☐ **No**

	Print Name	Signature	Date
Parent / Guardian			
Witness			
Educational Surrogate Parent (*if applicable*)			

Child/Youth's Name: _____

Section I should be filled out PRIOR to the CSP WITH THE FAMILY

I. Child/Youth & Family Information

Child/Youth's Name:	Assigned Gender at Birth: ☐ Male ☐ Female Gender Identity (Optional):
Date of Birth: Age:	Which of these describe the child/youth **as identified by family** *(Check all that apply):* ☐ Abenaki ☐ Alaska Native ☐ American Indian ☐ Asian ☐ Black/African American ☐ Middle Eastern or North African ☐ Native Hawaiian/Other Pacific Islander ☐ Hispanic, Latino, or Spanish ☐ White ☐ Other ☐ Unreported/Chose not to answer
Name(s) of individuals who have custody of this child/youth: *As well, see documentation list which requires a custody order be provided outlining who has decision-making authority (physical custody and/or medical decision-making).*	
Name of Parent:	Physical Address: Mailing Address: Phone: E-mail:
Name of Parent:	Physical Address: Same as above ☐ Mailing Address: Phone: E-mail:
Legal Guardian (if applicable)	Address: Phone:
Educational Surrogate Parent (*if applicable*):	Address: Phone:
Name(s) and Contact Information of Current Caregiver (if different than above):	
If involved with DCF, please fill out Section E.	

Child/Youth's Name: _____

A. Behavioral and Mental Health

DSM-5 Diagnosis	ICD Code	Date	Provided by
1			
2			
3			
4			
List medications currently taken:			

B. Medical Information

Primary Care Doctor:		
Medical Issue or Diagnosis	**Date**	**Provider**
1		
2		
3		
List medications currently taken:		
Has this child/youth been found eligible for developmental disability services? ☐ Eligible; receiving services ☐ Eligible; services pending ☐ Evaluation in process ☐ Assessed; found ineligible ☐ Need to refer If yes, year of eligibility: _____ Designated Agency that made the determination: _____		

C. Health Insurance

Does the child/youth have health insurance? ☐ No ☐ Yes

☐ Medicaid - *Number*: ☐ Third Party/Commercial – *Carrier and number:*

D. Adoption Status

Was the child/youth adopted? ☐ Yes ☐ No ☐ Pending

How old was the child when they were adopted? _____

E. DCF Involvement

Fill in all that are applicable.	
Is child/youth in DCF custody?	☐ Yes ☐ No
Is there a current Conditional Custody Order?	☐ Yes ☐ No If so, to whom?
Is there an open family case with DCF?	☐ Yes ☐ No
DCF Social Worker	
Is the youth on juvenile probation?	☐ Yes ☐ No
Is the youth on Youthful Offender Status?	☐ Yes ☐ No
Adult Youth Specialist Probation Officer through the Department of Corrections	
Guardian Ad Litem	

Child/Youth's Name: _____

Information to be filled out at the CSP Meeting

I. Reason for Referral

What is the reason for the referral?		
CSP:	Date:	Next Meeting Date:
LIT: (if applicable)	Date:	
CRC: (if applicable)	Date:	
SIT: (if applicable)	Date:	

II. Facilitator(s) of Meeting

Name of CSP Facilitator(s)	Agency: Address: Phone Number: E-mail:
Name of LIT Coordinator	Agency: Address: Phone Number: E-mail:

III. CSP Team Participants

Name (Please Print)	Signature and Relationship to Child/Youth	For follow up meetings- please initial if you attended

IV. Social Connections: Who Is Important to Me and My Family?

People who are important or helpful to me and my family (for example, family, extended family members, friends, neighbors, people from place of worship, community agencies, school, child care, other service providers, health care providers.)

This information could be provided as a basic genogram or eco-map, but it is not required to be provided in this manner. To find out more information about how to do genograms and eco-maps you can go to: http://stanfield.pbworks.com/f/explaining_genograms.pdf or https://www.smartdraw.com/ecomap/.

If the child/youth is not present at the CSP, be sure to get their feedback as to who is important and who to include -- team members (sports, clubs, civic groups), teachers, coaches, peers, mentors.

How do I, as the caregiver, prefer to receive support?

(i.e. Do I prefer to see written materials, hear about it, talk about it, meet someone who is having similar challenges, need an interpreter because I'm an English learner, need accommodations for a visual or hearing impairment?)

V. Resiliency Factors and Needs: What's Important to Know about Me (Child/Youth) and My Family?

1. What are the hopes and goals for me (child/youth) and for my family (goals as they relate to the child/youth)?	
2. What are my (child/youth) strengths, interests and resources and those of my family that can help support the hopes and goals?	
3. What are my (child/youth) needs, challenges, concerns, and priorities that must be considered to achieve my goals? (*Use existing plans and assessments as well as current experience to identify these.*)	

VI. Behavioral Concerns

Please complete the checklist below, if relevant, based on the reasons for the CSP being held. If the referral is through the Department of Mental Health, attach the most recent Child and Adolescent Needs and Strengths (CANS) summary which shows the needs and strengths.

Check all the boxes listed below where the child/youth has exhibited the behavior **to a marked degree when compared to others in his/her age group**.

☐ None of the following apply		
☐ confused/strange ideas	☐ impulsive	☐ extreme sadness
☐ inappropriate behavior	☐ runs away	☐ anxiety (could include obsessive/compulsive behaviors)
☐ emotionally problematic reactions	☐ sensory challenges	☐ substance use
☐ avoidance of social contact and/or social isolation	☐ fire setting OR fire play	☐ physical (somatic) complaints with unknown medical cause
☐ hyperactivity	☐ refusal to accept limits	☐ bowel and bladder issues (enuresis/encopresis)
☐ verbal aggression	☐ self-harming behavior	☐ persistent school refusal
☐ aggression towards people	☐ suicidal thoughts	☐ school suspension/expulsion
☐ aggression towards property	☐ suicidal behavior	☐ motor or verbal tics
☐ sexually problematic behavior	☐ stealing	☐ serious sleep disturbance
☐ extreme withdrawal from family	☐ cruelty to animals	☐ problems with the law
☐ extreme dependence on family	☐ eating disorder	☐ other
☐ challenges adjusting to trauma	☐ threatening behavior involving weaponry	
Please expand upon the above behavioral concerns and the settings in which they occur:		

VII. Child/Youth's Educational Status

School Attending*: District/Supervisory Union: **If child/youth is home-schooled, indicate that under school attending*		Town where parent(s) reside:
Grade:	School contact (name & role):	Phone:

A. Special Education Status

☐ Eligible; on IEP ☐ Eligible; IEP pending	☐ Evaluation in process ☐ Assessed; found ineligible	☐ Need to refer	
Disability:	Primary	Secondary	Other
If 16 years old or older, is transition plan included in IEP? ☐Yes ☐No			

Special Education Administrator:	Phone:
Please describe anything notable regarding cognitive or adaptive functioning:	

B. Section 504/EST Status

☐ 504 Plan ☐ Need to refer	504 Coordinator:	Phone:
☐ EST Plan ☐Need to refer to EST Coordinator:		Phone:

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

Kind of Placement (*check all that apply*)	**Previous**	**Current**	**Proposed**
General Education Classroom or Early Care and Learning	☐	☐	☐
General Education Classroom + in-class support and/or accommodations	☐	☐	☐
General Education Classroom + specialized instruction and/or other supports outside classroom (may include school-based early childhood special education, Headstart)	☐	☐	☐
Separate Classroom/Alternative LEA Program (may be on or off school grounds)	☐	☐	☐
Independent School/Day Treatment Program	☐	☐	☐
Tutorial	☐	☐	☐
Residential School	☐	☐	☐
Homebound or Hospitalized Instruction	☐	☐	☐
Home Study ("home schooled")	☐	☐	☐
Not in school - obtained General Educational Development (GED) Degree	☐	☐	☐
Not in school - dropped out/suspended/expelled	☐	☐	☐
Other (*describe*):	☐	☐	☐
Please describe proposed educational placement (this may be subject to an IEP team decision):			

VIII. Supports and Services for Child and Family

This information is specific to the child's needs and voluntary for the family to provide. This list is meant to generate ideas about supports and services that may be helpful. It is not meant to be all inclusive or to limit creative and individualized thinking.

Services	**Agency Providing or Agency Proposed to Provide**	**Previous**	**Current**	**Proposed and by when**
Child Care/After school program		☐	☐	☐ _____
Mentoring		☐	☐	☐ _____
Assessment: ☐Psychological ☐Medical ☐Neurological ☐Substance Use ☐Other		☐	☐	☐ _____
Behavior Support		☐	☐	☐ _____

Child/Youth's Name: _____

Services	Agency Providing or Agency Proposed to Provide	Previous	Current	Proposed and by when
Case Management/Service Coordination		☐	☐	☐ _____
Respite ☐Hourly ☐Overnight		☐	☐	☐ _____
School-based Clinician		☐	☐	☐ _____
Counseling: ☐Family ☐Individual ☐Group		☐	☐	☐ _____
Intensive Family Based Services		☐	☐	☐ _____
Home-based Parenting Support		☐	☐	☐ _____
Medication		☐	☐	☐ _____
Community Skills Work		☐	☐	☐ _____
Substance Use Treatment (for youth)		☐	☐	☐ _____
Vocational/Employment Services		☐	☐	☐ _____
Home and Community Based Services/ Developmental Services ("waiver")		☐	☐	☐ _____
Children's Personal Care Services		☐	☐	☐ _____
High Tech Nursing Services		☐	☐	☐ _____
Post Permanence Support and/or Subsidy (Adoption or Guardianship Assistance)		☐	☐	☐ _____
Family Safety Planning/Family Group Conference		☐	☐	☐ _____
SSI Benefits		☐	☐	☐ _____
Transportation		☐	☐	☐ _____
Services to address Family Violence		☐	☐	☐ _____
Other (*describe*):		☐	☐	☐ _____
Other (*describe*):		☐	☐	☐ _____
Other (*describe*):		☐	☐	☐ _____
Other (*describe*):		☐	☐	☐ _____
Other (*describe*):		☐	☐	☐ _____

IX. Proactive Crisis Plan

Teams are strongly encouraged to develop a proactive crisis plan if the child or youth is medically fragile, has ever been hospitalized in a psychiatric setting, or demonstrates risky or unsafe behaviors. You may attach existing agreed upon behavior plan or safety plan documents that address needs across environments.

1. A Crisis Plan is needed ☐ Yes If yes, answer questions 2 through 8 below ☐ No, If no, why not?
2. What does a crisis look like?
3. What are the triggers/stressors that might lead to a crisis?
4. What are the coping strategies that can be used to prevent a crisis? (Describe skills and strategies to prevent, reduce or de-escalate crisis.)
5. What are the strategies that the child and others can use during a crisis to ensure safety and encourage de-escalation?
6. Who are the key people to be contacted and when should they be contacted?
7. What should one NOT do in a crisis?
8. When should the police, mental health screeners, and/or hospital be involved?
PLEASE NOTE: *There may be special or unusual circumstances that will require the responsible adults to modify the plan.*

X. Follow-up and Next Steps

Date and Time for CSP Follow-up Meeting:
Next Steps and Who Is Responsible • •

Important Note: *Any member of a CSP team, including the parent, can make a referral to their Local Interagency Team if the team would like additional supports, ideas, and/or suggestions for more supports and services.*

Appeals 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 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 neither the Local Interagency Team nor the State Interagency Team is able 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 3. The hearing shall be conducted by a hearing officer appointed by the Secretary of the Agency of Human Services and the Secretary 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 AHS and AOE Secretaries may affirm, reverse, or modify the proposals for decision. All parties shall receive a written final decision by the Secretaries.

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 Appeals and 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 appeals and grievance procedures depending on the nature of the service and complaint. Those appeals, and grievance procedures may include but are not limited to:

- 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 Agency of Education at (802) 479-1255.
- Parents and children have the right to appeals related to Medicaid Coverage and/or appeals related to whether a child qualifies for Medicaid: Contact Vermont Health Connect, Green Mountain Care Customer Support Center at 1-800-250- 8437 (TDD/TTY) 1-888-834-7898.
- Complaints or grievances regarding staff performance or quality of programs: Contact the supervising provider responsible for service delivery.

Child/Youth's Name: _____

Release of Information for Interagency Team Review of Coordinated Services Plan

This release must be signed by the parent if a referral is being made to the Local Interagency Team, Case Review Committee or State Interagency Team

Child/Youth's Name	Facilitator

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 and/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 facilitator.
- Members of LIT, SIT, and/or CRC know that my child's information is confidential and 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 facilitator, 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.	☐ Yes ☐ No

	Print Name	**Signature**	**Date**
Parent / Guardian			
Witness			
Educational Surrogate Parent (*if applicable*)			

Child/Youth's Name: _____

Supplemental Section:
Referral to Case Review Committee

*In addition to the CSP packet, this section **must** be completed if a referral is being made to the Case Review Committee for Consideration of a Residential Placement.*

The Case Review Committee (CRC) was created by the State Interagency Team (SIT) with the purpose of working with local teams to develop appropriate Coordinated Service Plans for children. The CRC is committed to serving children and adolescents with severe emotional disturbances and other disabilities as defined in the AOE/AHS Interagency Agreement in the least restrictive setting appropriate to their needs. The SIT and the CRC believe that, if possible, children should be served within their own communities. Intensive residential treatment should be used only when necessary to meet the individual needs of a child.

The CRC has been established as a subcommittee of the State Interagency Team to achieve two objectives ***applying consistent criteria:***

1. to provide assistance to local teams as they identify, access and/or develop less restrictive treatment alternatives; and
2. when less restrictive alternatives are not appropriate, to assure the best possible match between child and residential treatment facility.

For full CRC guidelines please visit the IFS website at: http://ifs.vermont.gov/docs/sit.

Residential Referral Questions

The following questions are to be completed by the CSP Team or Local Interagency Team, whichever team is making the referral to the Case Review Committee.

Important Information
If applying for residential treatment, and the child was adopted, does the DCF Adoption Unit know the family is applying for residential treatment? ☐ Yes ☐ No Note: *It is the family's responsibility to notify the Adoption Unit of such a change in residence for the child/youth.*
If the child/youth is in DCF custody: What was the parent(s)'s town of residence at time of custody? Have parental rights been terminated (TPR)? ☐ No ☐ Yes *If yes*, parents' town of residence at time of TPR:
Person(s) who has authority for medical and educational decision-making:
If the child/youth has commercial insurance, indicate you have checked with their insurance to see if they offer the benefit of covering residential treatment. ☐ Yes, they do ☐ No, they do not
Risk Factors (*check all that apply*) Substantiated victim of: ☐ Physical abuse ☐ Neglect ☐ Sexual abuse ☐ Emotional abuse ☐ Adjudicated for sexually harmful behaviors ☐Substantiated perpetrator of sexual abuse ☐ Other adjudication (describe): ☐ Other risk factors (describe): ☐ History of human trafficking ☐ History/current exposure to domestic violence ☐ Other trauma history:

1. What are the barriers that prevent the needs of the child/youth from being met in the community?

2. Please answer ONE of the following questions--If you are requesting an assessment, answer (a) if you are requesting residential treatment, answer (b).

a. If you are requesting an assessment, what are the clinical and/or educational questions you wish to have answered?

b. If you are requesting residential treatment, what are the goals for this level of intensive intervention? What are the goals of the family and child/youth?

3. What will parent/family involvement look like during residential treatment?

4. Please tell us about any anticipated challenges with parent/family involvement in treatment.

5. Are there recommendations for services in the home while the child/youth is in treatment? If yes, please describe.

6. How will the team know there is progress? What outcomes are they looking for?

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

Child/Youth's Name: _____

Child/Youth's Living Situation

Please check the appropriate boxes to indicate the youth's previous, current, and proposed living situations and placements and include the dates on the line.

Type (*Check all that apply and include dates.)*	**Previous**	**Current**	**Proposed**
Independent Living	☐ _____	☐ _____	☐ _____
Two Caregivers (at least one biological)	☐ _____	☐ _____	☐ _____
One Biological Parent Only (without partner)	☐ _____	☐ _____	☐ _____
Shared Parenting	☐ _____	☐ _____	☐ _____
Adoptive Home	☐ _____	☐ _____	☐ _____
Relatives/Unpaid Adult	☐ _____	☐ _____	☐ _____
Foster Care	☐ _____	☐ _____	☐ _____
Therapeutic Foster Care	☐ _____	☐ _____	☐ _____
Group Home	☐ _____	☐ _____	☐ _____
Emergency Shelter	☐ _____	☐ _____	☐ _____
Residential Treatment Program Assessment	☐ _____	☐ _____	☐ _____
Residential Treatment - Long-term (non-substance/alcohol)	☐ _____	☐ _____	☐ _____
Substance/Alcohol Residential Treatment Program	☐ _____	☐ _____	☐ _____
Medical Hospital	☐ _____	☐ _____	☐ _____
Psychiatric Hospital	☐ _____	☐ _____	☐ _____
Secure Juvenile Facility	☐ _____	☐ _____	☐ _____
Correctional Facility	☐ _____	☐ _____	☐ _____
Detention Alternatives	☐ _____	☐ _____	☐ _____
No Place to Stay	☐ _____	☐ _____	☐ _____
Other (*describe*):	☐ _____	☐ _____	☐ _____
Other (*describe*):	☐ _____	☐ _____	☐ _____
Please describe proposed living situation:			

Child/Youth's Name: _____

Residential Referral Signature Page

Signature of Parent/Guardian: Always required.

Name, Role and phone number	Signature	Date	Residential Referral	
			Agree	Disagree
			☐	☐
			☐	☐

Signature of Educational Administrator: If the child is on an IEP, the Special Education Director is required to sing. If the child is not on an IEP (*i.e.,* child is on a 504 plan, EST plan, or in regular education), the signature of either the Principal or Special Education Director is required (as determined by local procedures).

Name, Role and phone number	Signature	Date	Residential Referral	
			Agree	Disagree
			☐	☐

Signature of the Division of Family Services District Director: If the child/youth is in custody of the commissioner of the Department for Children and Families, this is a required signature.

Name, Role and phone number	Signature	Date	Residential Referral	
			Agree	Disagree
			☐	☐

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

Name, Role and phone number	Signature	Date	Residential Referral	
			Agree	Disagree
			☐	☐

Signatures of Other Team Members:

Name, Role and phone number	Signature	Date	Residential Referral	
			Agree	Disagree
			☐	☐
			☐	☐
			☐	☐