SHELBY COUNTY FAMILY & CHILDREN FIRST COUNCIL

SHELBY COUNTY DIVERSION ASSESSMENT TEAM REFERRAL

please scan completed referral to drodrigues@shelbydd.org.

REFERRAL FROM:____DATE:______________

AGENCY, CASE MANAGER & PHONE #

FAMILY BEING REFERRED:______________________________________PHONE:________________

ADDRESS:____________________________________CITY:________________ZIP:____________

MEMBERS OF HOUSEHOLD	***RELATIONSHIP***	***SSN***	***D.O.B.***	***Age***	***SCHOOL/GRADE***

- **Is there a Mental Health Diagnosis? Yes ☐ No ☐ Please list**________________________________
- **Family Primary Care Physician**________________ **Managed Care Plan if applicable**______________

PARENT'S EMPLOYMENT & INCOME STATUS:____

REASON FOR REFERRAL. GIVE SUMMARY OF FAMILY NEEDS AND CONCERNS. (Please be specific):

CURRENT OR PREVIOUS INVOLVEMENT WITH ANY OF THESE PARTNERING AGENCIES: Check all that apply

☐Job & Family Services/Children Services
☐Shelby County Juvenile Court
☐Shelby County Victim Services
☐Law Enforcement
☐Shelby County Counseling Center
☐Catholic Social Services
☐Shelby County Board of DD
☐Sidney-Shelby County Health Department
☐OhioRise
☐Bridges Community Action
☐Bureau of Vocational Rehab
☐New Choices
☐Head Start
☐Ohio Early Intervention
☐Big Brothers/Big Sisters
☐Shelby County YMCA
☐Sidney City Schools
Other _______________
☐Consumer Credit Counseling
☐Salvation Army
☐GAL/CASA
☐DAT
☐Church
☐Shelby County Schools
☐Family Resource Center
☐Journey 4 Self

OFFICE USE ONLY: Date Referral Received:______________________

DATE__________**OUTCOME OF REFERRAL** ACCEPTED REFERRED FOR SERVICES/NOT ACCEPTED

Services will be responsive to cultural, racial and ethnic differences and will be provided in the least restrictive environment as possible.

Revised 12-21

RELEASE OF INFORMATION:

I,____, (parent/guardian) authorize:

ANY OF THESE PARTNERING AGENCIES: *(please place a check mark in the box)*

☐ Shelby County Family & Children First Council

Job & Family Services/Children Services	Bridges Community Action	Consumer Credit Counseling
Shelby County Juvenile Court	Bureau of Vocational Rehab	Salvation Army
Shelby County Victim Services	New Choices	GAL/CASA
Sidney/Shelby County Health Department	Ohio Early Intervention	DAT
Law Enforcement	Head Start	Family Resource Center
Shelby County Schools	Family Resource Center	PAC – Parent Advocacy Connection
Big Brothers/Big Sisters	Catholic Social Services	Shelby County Board of DD
Journey 4 Self	OhioRIse	Other ________________

to share/exchange/give/receive/re-disclose case information about my child(ren) and family with the Shelby County Diversion Assessment Team, which is a committee of the Shelby County Family & Children First Council, designed to meet the needs of Shelby County youth and families. Such information may be necessary to develop a comprehensive family plan for the above named family.

☐ SOC(Systems of Care) Uses/Discloser's: I further authorize*: (please place a check mark in the box)*

- Sharing of information with regional and local family advocates for treatment advocates for treatment advocacy and program evaluation purposes.
- Sharing of information across child-servicing agencies and systems.
- Disclosure of information to behavioral health board for purposes of MACSIS enrollment, Outcomes tracking, and CCBH claiming.
- ODADAS disclosure of behavioral health measures to OSU/CFR.
- MACSIS staff performing service inventory runs.
- Use of information and merging of data by ODMH/ODADAS, acting through the OSU, for evaluation to identify and measure differences in the amounts and types of services utilized before and after participation in the program; indicators of youth well-being before and after participation in program; levels of family empowerment/family involvement in treatment before and after participation in program; and to assess services effectiveness in reducing levels of risk factors for youth and families, increasing family stability, and increasing family satisfaction.
- Service/treatment data for period 6 months prior to enrollment in program and throughout enrollment in program (MACSIS and checklist of non-MACSIS services; also to be derived from interviews with caregivers).
- Results of interviews with adult primary caregivers regarding caregiver wants and needs.
- Family satisfaction surveys.
- Outcome measures.
- Demographic data on youth/family (from MACSIS).
- Family stability measures-self reported info obtained via interviews.
- Family empowerment-self reported information obtained via interviews.
- AoD BH measures re: sobriety.

I further authorize the following information to be released: (please check all that apply)

___Juvenile Court Records	___Psychological Reports	___School Attendance Records
___Police Reports	___Counseling Reports	___Scholastic Records
___Children Services Records	___Drug & Alcohol Records	___Medical Records
___Other: ________________________		

DOES THE FAMILY WISH TO HAVE A PARENT REP. WHO CAN PROVIDE SUPPORT TO THE FAMILY (Please place a check mark) Yes____________ No ____________

I understand that this information will be released only to the above named agency/person/program and any information released to the diversion assessment team will not be re-released without prior authorization**. I also understand that this release will cover all family members listed on this release.**

I further understand that these records are protected by state and/or federal confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. In addition, I understand that I may revoke this consent at any time. In any event, this consent **automatically expires 365 days** from the date below.

Parents have the right to formally initiate the dispute resolution process in regards to their service coordination services they receive by DAT.

Signature of Parent(s) or Guardian(s):____ Date:________________

Witness:____Date:__________________________

Revised 12-21