

Note: System of Care Services are voluntary for the family  
**CT System of Care Uniform Client Record: I. REFERRAL FORM/FACE SHEET**

<b>Child/Youth's Name:</b>			
<b>D.O.B.:</b>	<b>Age:</b>	<b>Gender: Male <input type="checkbox"/> Female <input type="checkbox"/></b>	
<b>Community Collaborative/System of Care:</b>			
<b>Was EMPS # Provided: Yes <input type="checkbox"/> No <input type="checkbox"/></b>		<b>Date of Referral:</b>	

<b>Referral Source Name:</b>		<b>Phone Number:</b>	
<b>Referral Source Code (please check a source code below):</b>			
<input type="checkbox"/> (1) Danbury DCF	<input type="checkbox"/> (14) National Runaway Hotline	<input type="checkbox"/> (27) Residential Facility	<input type="checkbox"/> (44) Employee Assistance Program
<input type="checkbox"/> (2) Torrington DCF	<input type="checkbox"/> (15) Crisis Intervention Hotline	<input type="checkbox"/> (28) Police	<input type="checkbox"/> (45) Juvenile Court, Probation or Parole
<input type="checkbox"/> (3) Waterbury DCF	<input type="checkbox"/> (16) Child Guidance Clinic	<input type="checkbox"/> (29) Hospital	<input type="checkbox"/> (46) Family Advocate
<input type="checkbox"/> (4) Manchester DCF	<input type="checkbox"/> (17) Court/Public Defender/Atty.	<input type="checkbox"/> (30) Friend	<input type="checkbox"/> (47) Extended Day Treatment
<input type="checkbox"/> (5) New Britain DCF	<input type="checkbox"/> (18) Youth Service Bureau	<input type="checkbox"/> (31) School	<input type="checkbox"/> (48) Emergency Psych. Treatment
<input type="checkbox"/> (6) Middletown DCF	<input type="checkbox"/> (19) Social Service Agency	<input type="checkbox"/> (32) Norwalk DCF	<input type="checkbox"/> (49) Intensive Family Preservation
<input type="checkbox"/> (7) Norwich DCF	<input type="checkbox"/> (20) Clergy	<input type="checkbox"/> (33) Hartford DCF	<input type="checkbox"/> (50) Parent Aide
<input type="checkbox"/> (8) Meriden DCF	<input type="checkbox"/> (21) Self	<input type="checkbox"/> (34) Physician	<input type="checkbox"/> (51) Partial Hospitalization
<input type="checkbox"/> (9) New Haven DCF	<input type="checkbox"/> (22) Parent	<input type="checkbox"/> (35) Willimantic DCF	<input type="checkbox"/> (52) Dept. of Social Services
<input type="checkbox"/> (10) Bridgeport DCF	<input type="checkbox"/> (23) Info-Line	<input type="checkbox"/> (37) Relative	<input type="checkbox"/> (53) Dept. of Mental Retardation
<input type="checkbox"/> (11) Stamford DCF	<input type="checkbox"/> (24) Foster Family	<input type="checkbox"/> (41) Substance Abuse Agency	<input type="checkbox"/> (54) Private Provider
<input type="checkbox"/> (12) Hotline DCF	<input type="checkbox"/> (25) Group Home	<input type="checkbox"/> (42) Local Systems of Care	<input type="checkbox"/> (62) Emergency Room
<input type="checkbox"/> (13) DCF Unspecified	<input type="checkbox"/> (26) Temporary Shelter	<input type="checkbox"/> (43) Insurance – HMO	<input type="checkbox"/> (63) Department of Corrections
			<input type="checkbox"/> (99) Other

Hispanic: Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>Child's Ethnicity (Please check applicable box):</b>		
<input type="checkbox"/> (5) Central American	<input type="checkbox"/> (12) Korean	<input type="checkbox"/> (20) Mexican
<input type="checkbox"/> (6) South American	<input type="checkbox"/> (13) Laotian	<input type="checkbox"/> (21) Cuban
<input type="checkbox"/> (7) Other Spanish Speaking	<input type="checkbox"/> (14) Thai	<input type="checkbox"/> (22) African American
<input type="checkbox"/> (8) West Indies/Islander	<input type="checkbox"/> (15) Vietnamese	<input type="checkbox"/> (23) Portugese
<input type="checkbox"/> (9) Cambodian	<input type="checkbox"/> (16) Asian Indian	<input type="checkbox"/> (24) Dominican
<input type="checkbox"/> (10) Chinese	<input type="checkbox"/> (18) Bi-Racial	<input type="checkbox"/> (99) Other (Please specify)
<input type="checkbox"/> (11) Japanese	<input type="checkbox"/> (19) Puerto Rican	
<b>Child's Race (Please check applicable box):</b>		
<input type="checkbox"/> (1) White	<input type="checkbox"/> (3) Asian American	<input type="checkbox"/> (23) Pacific Islander
<input type="checkbox"/> (2) Black	<input type="checkbox"/> (22) Native American	

<b>Child/Youth's Residing Address:</b>
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**CT System of Care Uniform Client Record: I. REFERRAL FORM/FACE SHEET (Continued)**

<b>Child's Current Living Arrangement (Please check applicable box):</b>	
<input type="checkbox"/> (0) Unknown	<input type="checkbox"/> (10) Residential Treatment Facility (Other than DCF Operated)
<input type="checkbox"/> (1) With either or both parents	<input type="checkbox"/> (11) Hospital in the Community, Psychiatric Unit
<input type="checkbox"/> (2) With relative other than parent	<input type="checkbox"/> (12) Hospital in the Community, Medical Bed
<input type="checkbox"/> (3) Foster home (in the community)	<input type="checkbox"/> (13) Psychiatric Hospital
<input type="checkbox"/> (4) Foster home (out of the community)	<input type="checkbox"/> (14) DCF Residential Treatment
<input type="checkbox"/> (5) With friend or family friend	<input type="checkbox"/> (15) DCF Psychiatric Hospital (Riverview)
<input type="checkbox"/> (6) Emergency shelter for children	<input type="checkbox"/> (20) Crisis Stabilization Bed
<input type="checkbox"/> (7) Family homeless shelter	<input type="checkbox"/> (98) Homeless
<input type="checkbox"/> (8) Safe Home/Host Home	<input type="checkbox"/> (99) Other
<input type="checkbox"/> (9) Group Home (Other than DCF Operated)	

<b>School</b>	<b>Grade:</b>	<b>Special Ed: Yes <input type="checkbox"/> No <input type="checkbox"/></b>	<b>Section 504: Yes <input type="checkbox"/> No <input type="checkbox"/></b>
<b>DCF Social Worker:</b>		<b>Phone:</b>	
<b>Parent(s)/Guardian(s) Name:</b>			
<b>Parent(s) Address:</b>			
<b>Phone: (Home)</b>	<b>(Work)</b>	<b>(Cell)</b>	<b>(Other)</b>
<b>Email Address:</b>			
<b>Is the biological parent the legal guardian? Yes <input type="checkbox"/> No <input type="checkbox"/></b>		<b>If no, who is?*</b>	

<b>Family Type (Please check applicable box):</b>	
<input type="checkbox"/> (5) Emancipated	<input type="checkbox"/> (12) Adoptive Family Two Caregivers
<input type="checkbox"/> (8) Biological Family Two Caregivers	<input type="checkbox"/> (13) Adoptive Family One Caregivers
<input type="checkbox"/> (9) Biological Family One Caregivers	<input type="checkbox"/> (14) Relative and/or Guardian Care Two Caregivers
<input type="checkbox"/> (10) Foster Family Two Caregivers	<input type="checkbox"/> (15) Relative and/or Guardian Care One Caregivers
<input type="checkbox"/> (11) Foster Family One Caregiver	<input type="checkbox"/> (99) None of the above

**CT System of Care Uniform Client Record: I. REFERRAL FORM/FACE SHEET (Continued)**

**Primary Language Parent (Please check applicable box):**

(1) English     (2) Spanish     (3) Other European     (4) Asian     (5) African     (98) Other     (99) Unknown

**Primary Language Child (Please check applicable box):**

(1) English     (2) Spanish     (3) Other European     (4) Asian     (5) African     (98) Other     (99) Unknown

**Please check all that apply:**

Child lives with: Mother     Father     Other  (Specify) \_\_\_\_\_

Other relevant family members/persons in household	Relationship	Age	School	Grade

**Other Referral Concerns:**

**Clinical Diagnoses (if known):**

**Diagnosed by/Date:**

**Child previously referred to Systems of Care:**  Yes     No    **If yes, what collaborative or region:**

**Service Providers – Current and Previous**

Dates	Name	Agency	Number

**CT System of Care Uniform Client Record: I. REFERRAL FORM/FACE SHEET (Continued)**

<b>Please note child's functional impairment/strengths in relation to: (Please check all applicable reasons for referral below)</b>		
<input type="checkbox"/> (1) Suicidal Ideation	<input type="checkbox"/> (22) Witness of Physical Assault	<input type="checkbox"/> (43) Sleep Disturbance/Sleep Disorder
<input type="checkbox"/> (2) Suicidal Attempts/Gestures	<input type="checkbox"/> (23) Victim of Physical Assault	<input type="checkbox"/> (44) Severe Sibling Conflict
<input type="checkbox"/> (3) Depressed	<input type="checkbox"/> (24) Victim of Other Violent Crimes	<input type="checkbox"/> (57) Police Contact
<input type="checkbox"/> (4) Self-Mutilation	<input type="checkbox"/> (25) Pregnancy of the Child	<input type="checkbox"/> (58) Property Damage
<input type="checkbox"/> (5) Other Self-Injurious Behavior	<input type="checkbox"/> (26) High Risk Behavior (Dangerous Play, Promiscuity)	<input type="checkbox"/> (59) Theft
<input type="checkbox"/> (6) Suicide by Family Member	<input type="checkbox"/> (27) Relocation of Family	<input type="checkbox"/> (60) Threat to Life of Others
<input type="checkbox"/> (7) Death or Loss of Significant Other	<input type="checkbox"/> (28) Peer Relationship Problems	<input type="checkbox"/> (61) Extreme Verbal Abuse
<input type="checkbox"/> (8) School Phobia	<input type="checkbox"/> (29) Physical Disability	<input type="checkbox"/> (62) Cruelty to Animals
<input type="checkbox"/> (9) Suspension from School	<input type="checkbox"/> (30) Homicidal Ideation	<input type="checkbox"/> (63) Social Contact Avoidance
<input type="checkbox"/> (10) Being Expelled from School	<input type="checkbox"/> (31) Homicidal Plan	<input type="checkbox"/> (64) Over Dependence on Adults
<input type="checkbox"/> (11) Running Away	<input type="checkbox"/> (32) Physical Violence/Aggression by the Child	<input type="checkbox"/> (65) Truancy
<input type="checkbox"/> (12) Being Expelled from Home	<input type="checkbox"/> (33) Oppositional Behavior	<input type="checkbox"/> (66) Academic Problems
<input type="checkbox"/> (13) Eating Disorder	<input type="checkbox"/> (34) Sexual Offending by the Client	<input type="checkbox"/> (68) Somatic Complaints
<input type="checkbox"/> (14) Alcohol Abuse	<input type="checkbox"/> (35) Sexual Abuse of the Client	<input type="checkbox"/> (71) Bladder Difficulties
<input type="checkbox"/> (15) Marijuana Abuse	<input type="checkbox"/> (36) Fire-setting	<input type="checkbox"/> (72) Non-Compliance
<input type="checkbox"/> (16) Amphetamine Abuse	<input type="checkbox"/> (37) Delinquent Activities	<input type="checkbox"/> (73) Strange Behavior
<input type="checkbox"/> (17) Other Substance Abuse	<input type="checkbox"/> (38) Symptoms of Psychosis (delusions, thought disorder, etc)	<input type="checkbox"/> (74) Hyperactive/Impulsive
<input type="checkbox"/> (18) Significant Time Living Apart from Parents	<input type="checkbox"/> (39) Severe Mental Illness not Specified Above	<input type="checkbox"/> (75) Attentional Difficulties
<input type="checkbox"/> (19) Severe Parent-Child Conflict	<input type="checkbox"/> (40) Anxiety-Related Symptoms	<input type="checkbox"/> (76) Poor Self-Esteem
<input type="checkbox"/> (20) Witness of Domestic Violence	<input type="checkbox"/> (41) Other problem not listed above	<input type="checkbox"/> (77) Sexual Acting Out
<input type="checkbox"/> (21) Witness of Homicide	<input type="checkbox"/> (42) School Refusal	<input type="checkbox"/> (93) Problematic Bowel Activity

**CT System of Care Uniform Client Record: I. REFERRAL FORM/FACE SHEET (Continued)**

<b>Area</b>	<b>Strengths</b>	<b>Reasons for Referral (Please enter codes from previous page)</b>	<b>Examples/Description of Behaviors</b>
<b>Home &amp; Family</b>			
<b>School</b>			
<b>Community</b>			

**Signature of parent/guardian is REQUIRED for processing**

"I understand that my signature gives the referring agency permission to share the above information necessary for the referral with the Care Coordinator for the local System of Care Collaborative. I understand that this information will be used to determine eligibility for the Systems of Care."

**Signature of Legal Guardian:** \_\_\_\_\_

**Date:** \_\_\_\_\_

FAVOR, Inc. ([www.favor-ct.org](http://www.favor-ct.org)) is a statewide family advocacy organization, run by and for parents/guardians of children with mental health needs in Connecticut. They work collaboratively with local Community Collaboratives/Systems of Care to help families who are referred for Care Coordination. The FAVOR Family Advocacy program provides trained Family Advocates who can assist families through individual advocacy, including help in learning how to effectively advocate for their child in school, juvenile justice services or other family-identified priorities. The advocates assist families in participating at meetings, provide information/help in learning how to access resources, and linkage to parent-to-parent support.

**I am not interested in FAVOR services at this time [ ]**

**I would like to receive additional information on FAVOR, Inc. [ ]**

**I would like my referral to be forwarded to FAVOR for Family Advocacy Services [ ]**

**Signature of Legal Guardian:** \_\_\_\_\_

**Date:** \_\_\_\_\_

## CT System of Care Uniform Client Record: II. ELIGIBILITY REVIEW

**NOTE:** Eligibility for Level III Care Coordination services is based on criteria in the Practice Standards For Systems of Care and the Care Coordination contract. Determination for eligibility must be based on (a) Severe Emotional Disturbance (confirmed by Axis I diagnosis or “diagnosable” behavioral or emotional problems); (b) need for multi-agency involvement (as reflected on the list providers on the Referral Form; and (c) risk of placement if services are not provided or return placement only if services are provided.

<b>Child/Youth's Name:</b>		
<b>Local Collaborative/System of Care:</b>	<b>Date:</b>	
<input type="checkbox"/> Child/family informed about the nature of the Systems of Care and services available through it*		
<input type="checkbox"/> Grievance procedure discussed with and provided to parent/guardian**		
<input type="checkbox"/> Discussion of confidentiality***		
<input type="checkbox"/> Discussion of mandated reporting requirements****		
<input type="checkbox"/> Discussion of Administration Service Organization (ASO)***** ASO Notified <input type="checkbox"/> Yes <input type="checkbox"/> No Date ASO Notified:		
<b>Current DCF Status*****</b>		
<input type="checkbox"/> (97) No known DCF Status	<input type="checkbox"/> (4) Committed FWSN	<input type="checkbox"/> (8) Voluntary Services
<input type="checkbox"/> (1) Dual Commitment	<input type="checkbox"/> (5) Protective Services	<input type="checkbox"/> (12) No current, but previous DCF involvement
<input type="checkbox"/> (2) Committed Abuse/Neglect/Uncared for	<input type="checkbox"/> (6) FWSN/Non-Committed	<input type="checkbox"/> (19) Non-committed Treatment Program
<input type="checkbox"/> (3) Committed Delinquent	<input type="checkbox"/> (7) Delinquent/Parole Services	<input type="checkbox"/> (28) 136 Filed
<b>Name of current/recent DCF Worker:</b>		
<b>Eligibility Outcome (please check one)</b>		
<input type="checkbox"/> Case Accepted for Level 3 Care Coordination		<input type="checkbox"/> Case Not Accepted for Level 3 Care Coordination
<b>Reason for Wait List:</b>		
(1) <input type="checkbox"/> Waitlist for CC (CC is full)	(6) <input type="checkbox"/> Not Applicable	
(2) <input type="checkbox"/> Specific service is unavailable (e.g., bilingual staff)	(7) <input type="checkbox"/> Transition pending from other case management service	
(3) <input type="checkbox"/> Ancillary support for family unavailable (e.g., transportation)		
(4) <input type="checkbox"/> Family is unavailable		
<b>Assessment Scheduled on:</b>	<b>Check Level to be provided:</b> <input type="checkbox"/> 1 <input type="checkbox"/> 2	
<b>Alternative Care Coordination Offered by:</b>		
<b>Agency:</b>	<b>Phone:</b>	
<b>Case referred to outside services:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please list the referrals made:		

\*See Operational Definitions – Systems of Care

\*\*See Operation Definitions – Grievance Procedure

\*\*\*See Operational Definitions – Right to Confidentiality

\*\*\*\*See Operation Definitions – Mandated Reporting

\*\*\*\*\*See Operational Definitions – ASO

\*\*\*\*\*See Operational Definitions – DCF Status

## CT System of Care Uniform Client Record: II. ELIGIBILITY REVIEW (Continued)

### Operational Definitions

\* A **System of Care** is a comprehensive spectrum of community-based mental health and other related necessary services. These services are coordinated by the Care Coordinator to meet the multiple and changing needs of children/adolescents who are SED and their families. The family will decide the types and mix of services provided. All services are voluntary for a family and they may choose not to accept services. However, if a family has a Treatment Plan with DCF they must still follow the plan, and the System of Care can only enhance services for the family.

\*\*A **Grievance Procedure** was established by Public Act #92-272. A family may appeal any decision made at any level of the System of Care within 45 days of the decision, including the denial of acceptance into the System of Care. At the time of intake families will be given a copy of their rights per the Practice Standards for Systems of Care. A copy of the Grievance Procedures will also be given to the family. This will include the name and phone number of the person to contact if they wish to appeal a decision.

\*\*\*Each System of Care shall inform the family of their **right to confidential** services. Each member of the System of Care will sign an confidentiality statement which states that information discussed at any level will not be shared outside of the meeting without the proper releases of information. Releases of information shall include the following information: what information will be shared, with whom the information be shared, and for what purposed the information is being shared. Families have the right to release only the information they deem necessary to obtain the requested services. Families should only be asked to sign the referral form for the System of Care before acceptance into the System. Other releases of information should be signed subsequently.

\*\*\*\*All service providers and Care Coordinators within the System of Care are "**Mandated Reporters**" under the law of the State of Connecticut General Status S17a-101(b) and must file a report of Suspected child Abuse/Neglect (DCF 136) with the DCF Hotline if they suspect that a child/adolescent may have been abused or neglected.

\*\*\*\*\*The Administrative Services Organization (ASO) is a state contracted entity that establishes a common administrative infrastructure between The Department of Social Services (DSS) and the Department of Children and Families (DCF). The purpose is to enhance behavioral healthcare by improving access to care, coordination of care, and quality of care. Through the services of one contracted organization (Value Options) that reports directly to DSS and DCF, publicly funded behavioral health benefits from the Medicaid program and from DCF grants and contracts are organized and monitored in a coordinated and integrated fashion.

The ASO will authorize admissions to various levels of care, track the care of individual children and groups of children across services, identify and assist children and families for whom existing services do not appear to be working, help consumers and others identify all available resources, and connect children and families to crisis services. Unlike the existing managed care companies, the ASO will not be at financial risk and the clinical protocols and rates will be determined by both Departments with input from parents, consumers, and providers. These changes will support a more transparent and collaborative system. The ASO's website is [www.ctbhp.com](http://www.ctbhp.com).

- \*\*\*\*\*
- No known DCF Status
  - Dual Commitment; Child has been committed under more than one category
  - Committed Delinquent: Child has been adjudicated delinquent and committed to DCF as a delinquent. Placement is at the discretion of DCF, an alternative such as a Group Home or Aftercare Parole Services, if placed other than Connecticut Juvenile Training School, will provide supervision. DCF has custody.
  - Committed FWSN: Child has been committed to the care and custody of the Commissioner of DCF after finding the family is a family with service needs.
  - Protective Services: Child is not committed to DCF, not in Non-committed Treatment Program, but child/family is receiving Regional Office services (including investigation)
  - FWSN/Non-Committed: Adjudicated FWSN without commitment to DCF
  - Delinquent/parole services; Adjudicated delinquent without commitment to DCF.
  - Voluntary Services: Child/Family has elected to participate in the DCF Voluntary Services program
  - No current, but previous DCF involvement
  - Non-committed Treatment Program

CT System of Care Uniform Client Record: III. SAFETY PLAN

SAFETY PLAN

Child's Name:	
Local Collaborative/System of Care:	Date:

Important Contacts:
CARE COORDINATOR: PHONE NUMBER:
THERAPIST/COUNSELOR: PHONE NUMBER:
CARE GIVER: PHONE NUMBER:
CARE GIVER: PHONE NUMBER:
CARE GIVER: PHONE NUMBER:
FAMILY /COMMUNITY SUPORTS: PHONE NUMBER:
FAMILY/COMMUNITY SUPPORTS: PHONE NUMBER:
FAMILY/COMMUNITY SUPPORTS: PHONE NUMBER:
EMERGENCY MOBILE PSYCHIATRIC SERVICES (EMPS): PHONE NUMBER:

Current Medications for the Child/Youth		
Name of Medication:	Dosage:	Prescriber/Phone Number
Are there any PRN's:		
Prescribed by:		

List the types of situations that may prompt a crisis (Describe who does what for each situation listed):
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CT System of Care Uniform Client Record: III. SAFETY PLAN

SAFETY PLAN

What specific techniques would be effective in resolving crises? What does the child respond to? What should be avoided? Please list examples (list example, steps to be taken, include strengths and resources):

What can help the caregiver in a crisis (resources, another caregiver stepping in, who will take the lead in the situation?)

**REMEMBER, YOU ARE THE EXPERT ON YOUR CHILD/YOUTH. IF YOU FEEL YOU NEED EMERGENCY ASSISTANCE AT ANY TIME, DON'T HESITATE TO MAKE THAT CALL. IF YOU ARE UNSURE, SOME SUGGESTED GUIDELINES ARE PROVIDED BELOW:**

Call Clinical Provider OR EMPS/EMS if:

- There are significant changes in child's mood/behavior
- Child has made suicide statement
- Child has made threat to cause serious harm to self or others
- Other (Specify)

Call 911 if there are any concerns regarding immediate safety:

- Child requires medical attention
- Child has made suicide gesture/attempt
- Child has made gesture/attempt to harm others
- Other (Specify)

Identified Behavior/Concern	Stress reducing strategies/ coping skills

**CT System of Care Uniform Client Record: IV. COMPREHENSIVE ASSESSMENT**

<b>Child's Name:</b>	<b>Date Assessment Began:</b>
<b>Local Collaborative/System of Care:</b>	

<b>Strengths and Needs</b> (As seen by the child and family)	
<b>Strengths</b>	<b>Needs</b>
<b>Child/Family:</b>	
<b>Safety:</b>	
<b>Social/Recreational:</b>	
<b>Psychological:</b>	
<b>Educational/Vocational:</b>	
<b>Legal:</b>	
<b>Living Situation:</b>	
<b>Medical:</b>	
<b>Cultural/Spiritual:</b>	
<b>Other:</b>	

**CT System of Care Uniform Client Record IV. COMPREHENSIVE ASSESSMENT**

**Family Vision**

Where would you like to see your family in six months?

If you could wave a magic wand and meet all of your family's needs what would that look like?

Self Care:

Child/Adolescent Substance Use:

History of neglect/abuse/trauma:

Identification of other members of the household needing mental health or substance use services:

**CT System of Care Uniform Client Record: IV. COMPREHENSIVE ASSESSMENT**

**Parent's Perception of stress level in the home: (1 = extremely calm and 10= extremely stressful)**

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**Clinical Diagnosis as reported by most recent contact with a clinician:**

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**AXIS I**

		Date:
		Date:
		Date:

**AXIS II**

		Date:

**AXIS III**

		Date:

**AXIS IV**

		Date:

**AXIS V (GAF)**

		Date:

**Child's Medications**

**Dosage:**

**Prescribed By:**

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Child's Insurance:     Husky A             Husky B             Private

Insurance Company:

Child's Insurance #:

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**CT System of Care Uniform Client Record: IV. COMPREHENSIVE ASSESSMENT**

Number of days absent from school in the past 60 days (last 2 months):		Expelled: Yes [ ]      No [ ]	Number of days suspended:
<b><i>Psychiatric Hospitalizations</i></b>			
Dates/Number of days in Hospital		Location	
<b><i>Partial Hospitalization Programs</i></b>			
Dates/Number of days in PHP		Location	
<b><i>Intensive Out-Patient</i></b>			
Dates/Number of days in IOP		Location	
<b><i>Extended Day Programs</i></b>			
Dates/Number of days in EDT		Location	
<b><i>Out of Home Placements</i></b>			
Dates/Number of days in Out of Home Placements:		Location	
<b><i>Outpatient Counseling</i></b>			
Dates/Number of days in Outpatient Counseling sessions:		Location	
<b><i>Emergency Mobile Psychiatric Services (EMPS)</i></b>			
Dates/Number of EMPS Occurrences:		Location	



**CT System of Care Uniform Client Record: IV. COMPREHENSIVE ASSESSMENT**

**Community Supports Identified:**

**Referrals Made:**

**Dates:**

**Key Information for Child Specific Team Meeting:**

**Releases Signed:**     Yes     No

I have reviewed the above document and am in agreement with the information contained within.

**Signature of Parent/Guardian:**

**Date:**

**Signature of Child/Youth:**

**Date:**

**Signature of Care Coordinator:**

**Date:**

**CT System of Care Uniform Client Record: V. CARE PLAN INFORMATION SHEET**

Note: Care Plan only sent to Team participants

**CARE PLAN AGREEMENT**

I,/We (Parent/Guardian/Majority Aged Individual) \_\_\_\_\_ authorize the members of the Child Specific Team to share and exchange information about my child/self:

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

To be held on \_\_\_\_\_ at \_\_\_\_\_

I understand that it is my right to attend this meeting and that the Practice Standards for the System of Care prohibit this meeting being held without my attendance. I have the right to invite only the persons that I want to attend and I reserve the right to ask anyone to leave at any time during the Child Specific Team.

All information will be held confidential and used only to coordinate/plan supports and services to meet the needs of my child and family and to follow-up on my child's Care Plan. I understand that all Team members present will sign a statement regarding the confidentiality policy at the start of the Team meeting.

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Child/Youth

\_\_\_\_\_  
Date

It is the obligation of the members of the Child Specific Team to adhere to the principles and terms of confidentiality outlined in this policy.

1. Communication with families/guardians originates with their confidence that any information shared and observed regarding them or their children will not be disclosed to anyone outside of the team without their written permission.
2. Privileged communication must be broken where the information disclosed by a child, family, guardian or individual gives reasonable cause to believe that a child's life or their life is in imminent danger (i.e., medical emergency, suicidal/homicidal risk, or where there is know or suspected abuse/neglect under applicable State of Connecticut General Statutes (Conn. Gen. Stat. S17a-101 (b) for mandated reporting).

As a member of the Child Specific Team, I understand that I may share and exchange pertinent information with only providers authorized on the Release of Information for this meeting, which is signed by the parent(s), legal guardian(s) or majority aged client(s). I understand that the team is parent/guardian driven, therefore, only the information on the signed release may be shared. As a member of the team, I understand that his meeting cannot start or be held if the parent/legal guardian is not in the room.\*

I, the undersigned, have read through this policy and my signature indicates that I will adhere to this policy as outlined above:

Child Specific Team Participants			
Print Name	Phone Number	Agency	Position/Role
<b>Signature:</b>			
Print Name	Phone Number	Agency	Position/Role
<b>Signature:</b>			
Print Name	Phone Number	Agency	Position/Role
<b>Signature:</b>			

**CT System of Care Uniform Client Record: V. CARE PLAN INFORMATION SHEET**

Note: Care Plan only sent to Team participants

**CARE PLAN AGREEMENT**

Child Specific Team Participants			
Print Name	Phone Number	Agency	Position/Role
<b>Signature:</b>			
Print Name	Phone Number	Agency	Position/Role
<b>Signature:</b>			
Print Name	Phone Number	Agency	Position/Role
<b>Signature:</b>			
Print Name	Phone Number	Agency	Position/Role
<b>Signature:</b>			
Print Name	Phone Number	Agency	Position/Role
<b>Signature:</b>			
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<b>Signature:</b>			
Print Name	Phone Number	Agency	Position/Role
<b>Signature:</b>			
Print Name	Phone Number	Agency	Position/Role
<b>Signature:</b>			
Print Name	Phone Number	Agency	Position/Role
<b>Signature:</b>			
Print Name	Phone Number	Agency	Position/Role
<b>Signature:</b>			
Print Name	Phone Number	Agency	Position/Role
<b>Signature:</b>			

## CT System of Care Uniform Client Record: V. CARE PLAN

<b>Name of Child:</b>		<b>Date:</b>	
<b>Identified Need #</b>	<b>Life Domain</b> (Please choose from codes below)		
	<input type="checkbox"/> (F) Family	<input type="checkbox"/> (L) Legal	
	<input type="checkbox"/> (S) Safety	<input type="checkbox"/> (LS) Living Situation	
	<input type="checkbox"/> (SR) Social/Recreational	<input type="checkbox"/> (M) Medical	
	<input type="checkbox"/> (P) Psychological	<input type="checkbox"/> (C) Cultural/Spiritual	
	<input type="checkbox"/> (E) Educational/Vocational	<input type="checkbox"/> (O) Other	
<b>Need:</b>			
<b>Desired Outcome:</b>			
<b>Action Steps/Strategies:</b>	<b>Person Responsible:</b>	<b>Timeframe:</b>	
<b>Supporting Strengths:</b>			
<b>Final Outcome:</b>			
<b>Date Need Met:</b>			
<b>Comments/Other:</b>			

Parent Guardian Initials: \_\_\_\_\_

Youth Initials: \_\_\_\_\_

**CT System of Care Uniform Client Record: V. CARE PLAN**

<b>Name of Child:</b> _____		<b>Date:</b> _____	
<b>Identified Need #</b>	<b>Life Domain</b> (Please choose from codes below)		
	<input type="checkbox"/> (F) Family	<input type="checkbox"/> (L) Legal	
	<input type="checkbox"/> (S) Safety	<input type="checkbox"/> (LS) Living Situation	
	<input type="checkbox"/> (SR) Social/Recreational	<input type="checkbox"/> (M) Medical	
	<input type="checkbox"/> (P) Psychological	<input type="checkbox"/> (C) Cultural/Spiritual	
	<input type="checkbox"/> (E) Educational/Vocational	<input type="checkbox"/> (O) Other	
	<b>Need:</b>		
<b>Desired Outcome:</b>			
<b>Action Steps/Strategies:</b>		<b>Person Responsible:</b>	<b>Timeframe:</b>
<b>Supporting Strengths:</b>			
<b>Final Outcome:</b>			
<b>Date Need Met:</b>			
<b>Comments/Other:</b>			

Parent Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Youth Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Care Coordinator Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**CT System of Care Uniform Client Record: VI. CASE CLOSING FORM**

<b>Child's Name:</b>		<b>DOB:</b>	
<b>Local Collaborative/System of Care:</b>			<b>Date:</b>
<b>Reason for Discontinuation of Service (Please check applicable box):</b>			
<input type="checkbox"/> (1) Presenting problem Resolved and child is Stable	<input type="checkbox"/> (9) Agency initiated Discontinuation		
<input type="checkbox"/> (3) Child/Family Moved	<input type="checkbox"/> (10) Child is Deceased		
<input type="checkbox"/> (4) Child's condition required outpatient care and/or community supports	<input type="checkbox"/> (11) Services to be provided by another agency/program		
<input type="checkbox"/> (5) Child's condition required inpatient treatment or residential treatment	<input type="checkbox"/> (12) Child removed from home/community by DCF		
<input type="checkbox"/> (6) Child chose to discontinue before presenting problem was resolved	<input type="checkbox"/> (13) Family chose to discontinue before presenting problem was resolved		
<input type="checkbox"/> (8) Incarcerated	<input type="checkbox"/> (99) Other		
<b>If other applies, please state the reason:</b>			
<b>Diagnoses at Closing</b>			
<b>Diagnosis:</b>	<b>Diagnosed By:</b>	<b>Date:</b>	
<b>Educational Status:</b>			
Grade Level: _____	Special Education: <input type="checkbox"/> Yes <input type="checkbox"/> No	Section 504: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Number of days absent from school 60 days prior to case closing:			
<b>Please identify ALL supports and services the child/youth &amp; family were connected with during the time the case was open. If other, please describe:</b>			
<input type="checkbox"/> (1) Emergency Mobile Psychiatric Services	<input type="checkbox"/> (22) DCF Residential Facilities (CCP & HM)	<input type="checkbox"/> (42) Recreational Services	
<input type="checkbox"/> (2) Care Coordination	<input type="checkbox"/> (23) Riverview Hospital	<input type="checkbox"/> (43) Organized Sport Services	
<input type="checkbox"/> (3) Family Advocacy	<input type="checkbox"/> (24) Substance Abuse Family Evaluation	<input type="checkbox"/> (44) Tutoring	
<input type="checkbox"/> (4) Extended Day Treatment	<input type="checkbox"/> (25) Alcohol and Drug Prevention	<input type="checkbox"/> (45) Religious Group Services	
<input type="checkbox"/> (5) Child Evaluation Services	<input type="checkbox"/> (26) Substance Abuse Screening	<input type="checkbox"/> (46) Volunteer Activity	
<input type="checkbox"/> (6) Out-Patient Services and Child Guidance Clinics	<input type="checkbox"/> (27) Multi-Systemic Therapy	<input type="checkbox"/> (47) Parent Aide	
<input type="checkbox"/> (7) Behavioral Health Consultation Services	<input type="checkbox"/> (28) Community Adolescent Out-Patient Substance Abuse	<input type="checkbox"/> (48) Vocational Services	
<input type="checkbox"/> (8) In Home Services	<input type="checkbox"/> (29) Adolescent Substance Abuse Evaluation	<input type="checkbox"/> (49) Peer Support Services	
<input type="checkbox"/> (9) Visiting Nurse	<input type="checkbox"/> (30) Substance Abuse Family At Risk	<input type="checkbox"/> (50) Comprehensive Case Manager	
<input type="checkbox"/> (10) Intensive Out-Patient Services	<input type="checkbox"/> (31) Substance Abuse Support Groups	<input type="checkbox"/> (51) Other Case Management	
<input type="checkbox"/> (12) Therapeutic Foster Care	<input type="checkbox"/> (32) Residential Substance Abuse – Short Term	<input type="checkbox"/> (52) Other Non-Traditional Services	
<input type="checkbox"/> (13) Therapeutic Child Care	<input type="checkbox"/> (33) Supportive Housing for Recovering Families	<input type="checkbox"/> (55) Department of Mental Retardation DMR	
<input type="checkbox"/> (14) Behavior Management Paraprofessional	<input type="checkbox"/> (34) Residential Substance Abuse	<input type="checkbox"/> (74) Psychiatric Evaluation	
<input type="checkbox"/> (15) Medication Management	<input type="checkbox"/> (35) Other Advocacy	<input type="checkbox"/> (76) Professional Mentoring	
<input type="checkbox"/> (16) Early Childhood Services	<input type="checkbox"/> (36) Informal Support Network for Parent	<input type="checkbox"/> (77) Non-Traditional Mentoring	
<input type="checkbox"/> (18) Crisis Stabilization Beds – Short Term	<input type="checkbox"/> (37) Entitlements, Concrete Services	<input type="checkbox"/> (78) Professional Translator/Interpreter	
<input type="checkbox"/> (19) In-Patient Psych Services	<input type="checkbox"/> (38) Camp	<input type="checkbox"/> (79) Non-Traditional Translator/Interpreter	
<input type="checkbox"/> (20) Partial Hospitalization	<input type="checkbox"/> (40) Family Preservation	<input type="checkbox"/> (80) Professional Respite Care for Patients	
<input type="checkbox"/> (21) Residential Treatment Centers	<input type="checkbox"/> (41) Family Reunification	<input type="checkbox"/> (81) Non-Traditional Respite Care for Patients	

**CT System of Care Uniform Client Record: VI. CASE CLOSING FORM**

If no code applies, please describe the service(s) below:

Using the Supports and Services list on the previous page, please identify all services that were needed but not available (list code numbers here):

Number of Admissions to Residential Treatment Facilities since case was opened:

Total number of Days in Residential Treatment Centers since case was opened:

Number of Psychiatric Hospitalizations since case was open:

Number of Days Hospitalized:

Number of Partial Hospitalizations/Program Admissions since case was opened:

Number of Days participating in Partial Hospitalization since case was opened:

Number of Outpatient Sessions:

Number of EMPS Interventions:

Number of Admissions to Extended Day Treatment since case was opened:

Number of Days of Extended Day Treatment since case was opened:

Number of Arrests since case was opened:

<i>OHIO Scales</i>					<i>BERS</i>	
	Child	Parent	Worker			Standard Score
Problem Severity					I. Interpersonal (IS)	
Functioning					II. Family Involvement (FI)	
Hopefulness					III. Intrapersonal Strength (IaS)	
Satisfaction					IV. School Functioning (SF)	
					V. Affective Strength (AS)	
					<b>BERS Strength Quotient:</b>	

**Parent's perception of stress level in the home: (1=extremely calm and 10=extremely stressful)**