Partnership *for* Children

www.pfcmt.org | (406) 541-1665

Referral Application for Therapeutic Group Care

-To expedite the referral process please attach any pertinent psychological evaluations, assessments, residential treatment homes, social history, and releases of information for collateral contacts. This referral may be emailed to Kim at kstevens@pfcmt.org and any questions call Kim at: 406-541-1665 or if you prefer faxed to ATTN: Kim Stevens at 406-721-0034

Date:_____

Referring Agency:_____

Referring Contact Person:_____**Phone Number: Work #**_____

Cell:_____ **Email Address:**_____

Address:_____

_____

Name of child being referred: _____ **SSN:**_____ - _____ - _____

Date of Birth:_____ / _____ / _____ **Age:**_____ **Sex:** M☐ F☐ **Height:**_____ **Weight:**_____

Race:_____ **Tribal Affiliation (If any):**_____

Childs Current Insurance Provider(s):_____

Healthy MT Kids or Healthy MT Kids Plus Medicaid ID #:_____

Child's Current Placement and for how long:_____

Current Address:_____

Why isn't this placement succeeding?

Placement Contact Person:_____

Phone Number:_____

Briefly describe child's need for care:

Briefly describe child's strengths:

Who should be considered a part of the Clients Treatment Team? (Relevant family members, community supports, therapists, school employees, CFS workers, CASA, CSCT, medication prescribers, physicians, juvenile probation officers, family based services, Missoula Urban Indian Health Center, etc.)

Name	Relation to Client	Contact Information

Who has legal custody of this child? _____

Legal Status? _____

Is Child and Family Services involved? ☐ **Yes** ☐ **No**

If yes: **Case Worker's name:** _____

Phone number: _____

County: _____

Have parental rights been terminated?

Mother: ☐ No ☐ Yes **Date:** _____ ☐ Unknown

Father: ☐ No ☐ Yes **Date:** _____ ☐ Unknown

Please detail the current involvement of the child's parent(s), siblings, and other significant individuals.

Placement History- (Please be detailed and provide info on why the placement did not work out, USE ADDITIONAL PAGE IF NEEDED)

Placement *(Foster families, group care, residential treatment, hospitalizations)*	Type of placement	Duration (Dates)

Educational History- (Please provide copy of IEP if available)

Current School: _____ **Current Grade:** _____

Educational Needs:	**Can this child attend full-day school?**	Yes	No
	Does the child have an IEP?	Yes	No
	Does child attend regular classroom?	Yes	No
	Full –time Special Education:	Yes	No

Details on school behaviors and academics: (If aggressive, detail aggression)

Special Needs or Behaviors-

Is child danger to self? Yes ☐ No ☐

Has child had: a. Suicidal Gesture: Yes ☐ No ☐

b. Suicidal Attempts: Yes ☐ No ☐

Suicide Risk Assessment: ☐ **Low** ☐ **Moderate** ☐ **High**

Other: Explain: _____

Aggression towards: ☐ Self ☐ Peers ☐ Adults

Please explain:_____

_____

Number of runaways from home: _____ **From placements**: _____

History of fire setting: No ☐ Yes ☐ Unknown ☐

History of cruelty to animals: No ☐ Yes ☐ Unknown ☐

History of explosive behaviors: No ☐ Yes ☐ Unknown ☐

History of sexual acting out: No ☐ Yes ☐ Unknown ☐

Does this child have a history of involvement with the juvenile justice system? ☐ No ☐ Yes ☐ Unknown

Date of most recent psychological/psychiatric evaluation and name of the person who completed the evaluation:

_____

DSM-V Diagnosis: _____

Are medications currently prescribed? ☐ No ☐ Yes ☐ Unknown

If yes, specify drug, dosage, and length of time on these medications: _____

_____

Name of prescribing physicians(s) and phone number: _____

_____

(PLEASE PROVIDE COPY OF PREVIOUS EVALUATIONS/ASSESSMENTS)

Please provide any additional information you feel is pertinent: _____

Completed applications may be emailed to kstevens@pfcmt.org or faxed to ATTN: Kim Stevens at (406) 721-0034

Authorization to Release Information

Name: _____ Date of Birth: _____ SSN: _____

I herby authorize Partnership for Children, 2825 Stockyard Rd Ste A-11, Missoula, MT 59808, and the following named agency, organization and/or persons, to communicate with and disclose to one another my protected health information as indicated below:

Name: _____ Relationship: _____

Organization\Agency: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____ Email: _____

Information to be released or obtained (check each box)

☐ Treatment Status	☐ Family Program info	☐ Treatment Plan
☐ Admission/Progress/Compliance	☐ Discharge Summary	☐ Parent-Child Therapy Records
☐ Assessment/Recommendations	☐ Intake/Assessment Summary	☐ Cost of Treatment/Billing info
☐ Continued Stay Reviews	☐ Progress report	☐ Entire Treatment Record
☐ Continuing Care Plan	☐ Progress Notes/MD notes	☐ Diagnostic Impressions
☐ Bio-Psych-Social Info	☐ Psychiatric Evaluation/Records	☐ Treatment Recommendations

Purpose of disclosure

Method of Disclosure: ☐ Mail ☐ Email ☐ Phone ☐ Fax ☐ In-person

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this consent in writing at any time except to the extent that action has been taken in

reliance on it. This consent expires on: _____

(specify date, event, or condition upon which consent expires)

I understand that I might be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or health care operations. I will not be denied services if I refuse to consent to a disclosure for other purposes. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may no longer be protected by federal confidentiality rules. I have read and understand this authorization.

Client Signature: _____ **Date:** _____

Guardian Signature: _____ **Date**: _____

Witness Signature: _____ **Date**: _____

NOTICE TO WHOMEVER DISCLOSURE IS MADE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.