Partnership for Children

Referral Application for Therapeutic Group Care

To expedite the referral process, please attach any pertinent psychological evaluations, assessments, residential treatment discharge summaries, social histories, and releases of information for collateral contacts.

Submit completed applications to: ***Danielle Dodge*** | *ddodge@pfcmt.org* | *Fax: 406-721-0034* | *Phone: 406-552-8686*

1 | Referring Agency Information

Date

Referring Agency

Referring Contact Person | **Office Number** | **Cell Number**

Email Address | **Address**

2 | Child Information

Full Name of Child Being Referred | **SSN**

Date of Birth | **Age** | **Sex** | **Height** | **Weight**

Race / Ethnicity | **Tribal Affiliation (if applicable)**

Current Insurance Provider(s)

Healthy MT Kids or HMK Plus Medicaid ID #

3 | Current Placement

Current Placement | **Duration at This Placement**

Current Address

Placement Contact Person | **Phone** | **Email**

Why isn't this placement succeeding?

4 | Presenting Needs & Strengths

Briefly describe the child's need for care:

Describe the child's strengths:

5 | Treatment Team

Who should be considered part of the client's treatment team? Include 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

6 | Legal Status & Family

Who has legal custody of this child? **Legal Status**

Is Child and Family Services (CFS) involved? ■ Yes ■ No

CFS Caseworker's Name **Phone Number** **County**

Have parental rights been terminated?

Mother	■ No ■ Yes Date: _____ ■ Unknown
Father	■ No ■ Yes Date: _____ ■ Unknown

Background information on biological parents

Diagnoses, substance use, involvement with law enforcement, developmental and physical disabilities

Current involvement of the child's parent(s), siblings, and other significant individuals:

7 | Placement History

Please be detailed and provide information on why each placement did not work out. Attach additional pages if needed.

Placement history narrative:

Summarize the child's overall placement history, patterns, and relevant context before listing placements below.

Placement (foster families, group care, residential treatment, hospitalizations)	Type of Placement	Duration (Dates)

8 | Educational History

Provide a copy of the IEP if applicable.

Current School **Current Grade**

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:
Provide details on aggression if applicable

9 | Special Needs & Behaviors

In-utero exposure to substances? *	☐ Yes ☐ No ☐ Unknown
Is child a danger to self?	☐ Yes ☐ No ☐ Unknown
Has child made a suicidal gesture?	☐ Yes ☐ No ☐ Unknown
Has child made a suicide attempt?	☐ Yes ☐ No ☐ Unknown
Suicide Risk Assessment	☐ Low ☐ Moderate ☐ High
History of fire setting?	☐ Yes ☐ No ☐ Unknown
History of cruelty to animals?	☐ Yes ☐ No ☐ Unknown
History of explosive behaviors?	☐ Yes ☐ No ☐ Unknown
History of sexual acting out?	☐ Yes ☐ No ☐ Unknown
History of involvement with juvenile justice system?	☐ Yes ☐ No ☐ Unknown

*** Substances exposed to (if applicable):**

Aggression towards: ☐ Peers ☐ Adults ☐ Self

Please explain aggression:

Number of runaways from home

Number of runaways from placements

10 | Clinical & Medical Information

Date of most recent psychological/psychiatric evaluation

Name of Evaluator

DSM-V Diagnosis:

Are medications currently prescribed? ☐ Yes ☐ No ☐ Unknown

If yes, specify drug, dosage, and length of time on each medication:

Name(s) of prescribing physician(s) and phone number

Any additional relevant information:

Please provide copies of all previous evaluations and assessments (neuropsychiatric, outpatient, school, occupational therapy, speech therapy, etc.).

Submit completed applications to Danielle Dodge:
Email: ddodge@pfcmt.org | Fax: 406-721-0034 | Phone: 406-552-8686

Partnership for Children

Authorization to Release Information

550 N. California St., Missoula, MT 59802

Client Name **Date of Birth** **SSN**

I hereby authorize **Partnership for Children**, 550 N. California St., Missoula, MT 59802, 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

Phone **Fax** **Email**

Information to be Released and/or Obtained

☐ 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.*

Partnership *for* Children

www.pfcmt.org

Submit completed applications to Danielle Dodge:
Email: ddodge@pfcmt.org | Fax: 406-721-0034 | Phone: 406-552-8686