All information should be received prior to a child/family being scheduled for the CSST. Incomplete information may delay a child/family from being placed on the schedule.

**A completed packet with supporting documentation must be sent to the CSST Facilitator, according to which county the child and family reside in. Upon receipt of the complete packet, the facilitator will contact the family and schedule them for the next available staffing date.**

The Child Specific Staffing Team is **NOT FOR AN EMERGENCY PLACEMENT**. The Team will read the information provided by the family and assist the family in clarifying what has and has not worked therapeutically. The team may identify resources that are available in the community that have not been tried and would be appropriate and helpful for the family.

The staffing team may be comprised of the following: Florida Medicaid Managed Medical Assistance Program (MMA) Representative, Central Florida Behavioral Health Network, Inc. or designee, Parent/ Guardian, Child, treating provider, and the parent/guardian invitees such as the Department of Juvenile Justice (DJJ), School Liaison (SEDNET), Family Advocate, or other persons invited by the family.

If the child has Medicaid and the parent/guardian has a completed packet, the family may choose to waive the staffing process for SIPP programs (not for TGH programs or requests for PRNM (non-Medicaid funding). The packet should be sent to the facilitator with the provider choice and the decision to waive the staffing. **For families who have Medicaid, the placement for residential services must be authorized by the individual Florida Managed Medical Program (MMA) prior to admission and each individual MMA plan will determine length of stay thru utilization management with each individual residential provider.** For all Waived Staffing’s, please specify Program of Choice where guardian would like packet to be sent to for review and CSST application must be sent to Florida Managed Medical Program (MMA) Plan (MMA plan contact information is listed towards end of this application and below is information to get further information on Florida Managed Medical Program (MMA) Plan).
The goal of the Child Specific Staffing Team is to have your child placed in the least restrictive setting meeting his/her needs. The Suncoast Region’s least restrictive out of home level of care is the Therapeutic Group Home. Non Residential Options are available in Pinellas, Hillsborough, Manatee/Sarasota/Desoto, Lee, Collier, and Polk/Hardee/Highland Counties thru Children’s Community Action Teams (CAT).

Children’s Community Action Team (CAT) is a self-contained multi-disciplinary clinical team. CAT provides comprehensive, intensive community-based treatment to families with youth and young adults, ages 11-21, who are at risk of out-of-home placement due to a mental health or co-occurring disorder and related complex issues for whom traditional services are not adequate. The CAT Team provides family-centered services individualized according to the strengths and needs of the child and family. The team and family work together with a goal of supporting and sustaining the youth or young adult in the most appropriate environment. Services provided and/or coordinated by the team include: Psychiatric (evaluation and medication management), Therapy (individual, group and family) counseling, Case Management, Mentoring, Crisis intervention & 24/7 on-call coverage/support, Educational system advocacy, coordination and tutoring, Legal system advocacy and coordination, Parenting skills/behavior modification, Family support network development, Employment/Vocational services, Life Skills Development, Respite Services.

The Following is a list of CAT (Community Action Team) Providers

1. **Collier County**: David Lawrence Center (239) 455-8500
2. **Hillsborough County**: Gracepoint (813) 239-8453
3. **Lee County**: SalusCare Florida (239) 931-9695 x1459
4. **Manatee, Sarasota, Desoto Counties**: Centerstone (941) 782-4396
5. **Pinellas County**: Personal Enrichment Through Mental Health Services (727) 362-4255
6. **Polk, Hardee, and Highland Counties**: Peace River Center (863) 519-0575 x 1105
7. **Pasco**: BayCare (727) 315-8638
8. **Charlotte Co**: Charlotte Behavioral Health (941) 639-8300
Medicaid & DCF Residential Options

A) **Specialized Therapeutic Group Home (STGH)** is an intensive, community-based, psychiatric, residential treatment service designed for children and adolescents with moderate-to-severe emotional disturbances. STGH is designed for youth who are ready for a step-down from a SIPP or to avoid placement into a SIPP. The goal of a STGH is to enable a youth to self-manage and to continue to work towards resolution of emotional, behavioral, or psychiatric problems. STGH placement is generally 6-9 months.

B) **Statewide Inpatient Psychiatric Program (SIPP)** is to stabilize a severely emotionally disturbed and/or psychiatrically unstable child in a short period, generally 2-6 months, within a restrictive and highly structured environment. This setting is appropriate only when least restrictive services have been attempted and have been unsuccessful.

**Children and adolescents meeting any one of the following criteria are not considered appropriate for care in a SIPP:**

1) Less intensive levels of treatment will appropriately meet the needs of the child or adolescent  
2) The primary diagnosis is substance abuse, mental retardation, or autism  
3) The recipient is not expected to benefit from this level of treatment  
4) The presenting problem is not psychiatric in nature and will not respond to psychiatric treatment  
5) The youth has a history of long standing violations of the rights and property of others  
6) A pattern of socially directed disruptive behavior (e.g. Gang involvement) is the primary presenting problem or remaining problem after any psychiatric issue has stabilized  
7) Recipients cannot be admitted to a SIPP if they have Medicare coverage, reside in a nursing facility or ICF/DD, or have an eligibility period that is only retroactive or are eligible as medically needy  
8) Lack of Medical Clearance from a physician for admission

**Families who are receiving Social Security Income benefits:** Please see the reporting procedures for SSI about change in residence with your child entering residential treatment. SSI requires notification about change in residence which may cause possible repayment of any funds received if notification to SSI office is not received.
**Child Specific Staffing Team (CSST) Facilitators by County**

Please send your completed packet with supporting documentation to the individuals below according to which county you and your child reside in.

**Collier County**
ATTN: Karen Buckner, LCSW
David Lawrence Center
6075 Bathey Lane
Naples, FL 34116
Phone 239.595.8479
Fax 239-643-7278
KARENB@dlcmhc.com

**Lee County**
ATTN: Stephanie Brooks
SalusCare Inc.
2789 Ortiz Ave
Fort Myers, FL 33905
Phone 239.275.3222 ext. 1112,
Fax 239.791.0111
Mobile 239.425-1524
E-mail: SBrooks@SalusCareFlorida.org

**Charlotte County**
ATTN: Gina Wynn
Jim Cox
Charlotte Behavioral Health Care
1700 Education Ave.
Punta Gorda, FL 33950
Phone 941.639.8300 ext. 2497
Fax 941.639.6831
GWynn@cbhcfl.org

**Pinellas County**
ATTN: Kelly Robbins
Carolee Binette
Directions for Living
8823 115th Ave. North, Largo, FL 33773
Phone 727.748-2294 Fax 727.547.4599
Mobile 727.270.3586
Email: KRobbins@directionsforliving.org,
Cbinette@directionsforliving.org

**Manatee County**
ATTN: Charles Whitfield
Centerstone
371 Sixth Ave. West
Bradenton, FL 34205
Phone 941.782.4203 Fax 941.782.4112
Email: Charles.whitfield@centerstone.org

**Sarasota & Desoto Counties**
ATTN: Erica Barker
Coastal Behavioral Health
12497 Tamiami Trail, North Port, FL 34236
Phone 941.492.4300 ext. 2132 Fax 941.492.2170
EBarker@coastalbh.org

**Hillsborough County**
ATTN: Jennifer Fitzgerald
719 US 301 South
Tampa, FL 33619
Phone 813.740.4811 ext. 260 Fax 813.740.4821
Email: cmh@cbhn.org

**Polk, Hardee, Highland County**
ATTN: Tiffani Fritzscbe
P.O. Box 1559
Bartow, FL  33831-1559
Phone 863.519.0575 ext. 6235
Fax 863-519-0528
mailto:tfritzsche@peacrivercenter.org

**Pasco County**
ATTN: Teri Turza, Program Coordinator,
Children’s Targeted Case Management & CSST
Facilitator for Pasco County
BayCare Behavioral Health
Phone 727.315.8862
Therese.turza@baycare.org
Suncoast Region’s Children’s Mental Health Community Providers

All children should be receiving Targeted Case Management (TCM) services prior to and throughout their residential program

**Charlotte County**
Charlotte Behavioral Health Care
Gina Wynn (941) 639-8300 ext. 2497
Jim Cox (941) 639-8300 ext. 2309

**Collier County**
David Lawrence Center
Karen Buckner (239) 595-8479

**Hillsborough County**
BNET
Delilah Fortenberry (813) 722-2882
Caring Community Counseling
Main Office (727) 367-2273
CFBHN *(For Staffings Only)*
Jennifer Fitzgerald (813) 740-4811 ext. 260
Chrysalis Health
Hillsborough Office (813) 443-4827
Life Share Management Group
Alexandria Wright (813) 891-9474
Success 4 Kids & Families
Artrelle Eubanks (813) 490-5490 ext. 219
(813) 724-4660

**Lee County**
Salus Care
Stephanie Brooks (239) 275-3222, ext. 1112

**Manatee County**
Centerstone
Ann Burke (941)782-4225
Charles Whitfield (941)782-4203

**Pinellas County**
Adoption Related Services of Pinellas
Email: referral@arsponline.org (727) 657-7761
Camelot
Dawn White (727) 593-0003 ext. 1101
Caring Community Counseling
Main Office (727) 367-2273
Chrysalis Health
Referrals- north@chrysalishealth.com (727) 231-4885
Directions for Living
Kelly Robbins (727) 748-2294
Carolee Binette (727) 547-4566 ext. 4411
<table>
<thead>
<tr>
<th>Pinellas County Cont.</th>
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<tbody>
<tr>
<td>PEMHS</td>
<td>Beth Lewis</td>
<td>(727) 545-6477 ext. 333</td>
</tr>
<tr>
<td>Sequel Care of Florida</td>
<td>Kate Malcolm</td>
<td>(727) 547-0607 ext. 116</td>
</tr>
<tr>
<td></td>
<td>Juan Costanza</td>
<td>(727) 547-0607 ext. 123</td>
</tr>
<tr>
<td>Suncoast Center for Community Mental Health</td>
<td>Larnetta Peterson</td>
<td>(727) 327-7656 ext. 4161</td>
</tr>
<tr>
<td></td>
<td>Kristen Brundage</td>
<td>(727) 327-7656 ext. 4130</td>
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<tr>
<th>Pasco County</th>
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<tr>
<td>BayCare Behavioral Health</td>
<td>Teri Turza</td>
<td>(727) 315-8862</td>
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<tr>
<td>Caring Community Counseling</td>
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<tr>
<td>Chrysalis Health</td>
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<tr>
<td></td>
<td>Main Office Referrals-</td>
<td></td>
</tr>
<tr>
<td></td>
<td><a href="mailto:north@chrysalishealth.com">north@chrysalishealth.com</a></td>
<td>(352) 205-4788</td>
</tr>
<tr>
<td>Sequel Care of Florida</td>
<td>Sherri Albaum</td>
<td>(727) 422-8431</td>
</tr>
<tr>
<td></td>
<td>Carisa Fleissner</td>
<td>(727) 494-7609</td>
</tr>
<tr>
<td></td>
<td>David Dohm</td>
<td>(727) 494-7609 ext 7003</td>
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<tr>
<th>Sarasota &amp; Desoto Counties</th>
<th></th>
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<tbody>
<tr>
<td>Coastal Behavioral</td>
<td>Erica Barker</td>
<td>(941) 492-4300 ext 2132</td>
</tr>
<tr>
<td>Desoto Psychiatric</td>
<td>Crisis 941.575.0222</td>
<td>(941) 639-8300</td>
</tr>
<tr>
<td>Providence Human Services of Florida</td>
<td>Counseling/TBOS/Med</td>
<td>(941) 359-1927</td>
</tr>
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<tr>
<th>Polk, Highlands &amp; Hardee Counties</th>
<th></th>
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<tbody>
<tr>
<td>Chrysalis Health</td>
<td>Referrals-</td>
<td>863-216-5636</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:north@chrysalishealth.com">north@chrysalishealth.com</a></td>
<td></td>
</tr>
<tr>
<td>Peace River Center</td>
<td>Tiffani Fritzsche</td>
<td>(863) 519-0575 ext. 6235</td>
</tr>
<tr>
<td></td>
<td>Donna Riringer</td>
<td>(863) 519-0575 ext. 7298</td>
</tr>
<tr>
<td>TriCounty Human Services</td>
<td>Kitty Stark</td>
<td>(863) 452-0106</td>
</tr>
<tr>
<td>Winter Haven Hospital</td>
<td>Maureen McIntire</td>
<td>(863) 293-1121</td>
</tr>
</tbody>
</table>
Child Specific Staffing Team (CSST) Checklist

Child’s Name: __________________________________________________________

Date of Birth: ______________ County of Residence: ______________________

It is highly recommended that all of these items and supporting documentation be in the “complete packet” before mailing to the CSST Facilitator to prevent delay in the process.

If any of these items do not apply to your child, please indicate this with N/A for not applicable.

The following item must be submitted to the CSST facilitator to proceed with a residential referral.

☐ A Psychiatric or Psychological Evaluation with recommendation for Statewide Inpatient Psychiatric Program or Group Home level of care within the last year completed by a licensed psychologist or psychiatrist that must include:

- The child has an emotional disturbance as defined in Section 394.492(5), F.S., or a serious emotional disturbance as defined in Section 394.492(6), F.S.;
- The emotional disturbance or serious emotional disturbance requires treatment in a residential treatment center; please specify Statewide Inpatient Psychiatric Program for Medicaid funded/eligible children or Residential Treatment Center for Non-Medicaid funded children or Specialized Therapeutic Group Care,
- All available treatment that is less restrictive than residential treatment has been considered or is unavailable;
- The treatment provided in the residential treatment center is reasonably likely to resolve the child’s presenting problems as identified by the licensed psychologist or psychiatrist;
- The treatment facility is qualified by staff, program and equipment to give the care and treatment required by the child’s condition, age, and cognitive ability;
- The child is under the age of 18; and
- The nature, purpose and expected length of the treatment Stay has been explained to the child and the child’s parent or guardian.

☐ A letter completed by the licensed psychologist or psychiatrist stating need for Therapeutic Group Home level of care or Statewide Inpatient Psychiatric Program level of care based on above criteria. The letter must include the criteria stated above and how that level of care will benefit the child.
☐ Previous Clinical Information which includes the following:
  - Previous Clinical Information (i.e., admission reports, evaluations, discharge summaries) from Baker Acts, Residential & Inpatient Admissions, Partial Hospitalizations, Outpatient Treatment, etc.

☐ Completed Children Specific Staffing Team (CSST) Application with release of information forms completed

☐ Completion of Summary Form in back of application for any waived staffing with program of choice identified.

☐ Medical & School Records (Please include physical and any medical records information that would be pertinent to treatment).

☐ Copy of Birth Certificate and Social Security Card

☐ Immunization Records

☐ Medical Stability Clearance and Dental Clearance - Physical within last 90 days

☐ IEP, if in Special Education (ESE Classification) or last Report Card, if Regular Education
  Most Recent IQ Score with supported documentation

☐ DJJ JJIS History Form (If Applicable)
  - JPO Name________________________________ Phone # _______________________

☐ Identification of a Targeted Case Manager (TCM) in Parent/Guardian County
  - TCM Name_____________________________ Phone # __________________________
    - Adoption Related Specialist: ________________________________________________

☐ Please check to ensure packet is complete before sending to CFBHN

Reviewed by: ________________________________ Date: __________________

Complete ______________  Incomplete: __________
Pre-Admission Medical Questionnaire for SIPP Admission

Name of Client: _________________________________________________  DOB: ___/___/____

Date of last Physical Check-Up: _______________ Date of Last Dental Check-Up: ____________

1. Has the child had a medical illness or injury since the last check up:
   Yes/No  If yes, please
   Explain: _________________________________________________________________________

2. Has the child visited a doctor other than his/her primary care provider in the last two years or was the child referred to a specialist even if an appt was never made?
   Yes/No  If yes, please
   Explain: _________________________________________________________________________

3. Has a physical ever denied/restricted the child’s participation in sports or activities for any heart problems?
   Yes/No  If yes, please
   Explain: _________________________________________________________________________

4. Does the child have any active of medical condition or chronic illness? This can include but not limit asthma, seizures, high blood pressure, HIV, Hepatitis B or C, sickle cell, heart disease, diabetes, etc.
   Yes/No  If yes, please
   Explain: _________________________________________________________________________

5. Does the child cough, sneeze, wheeze, or have trouble breathing during or after physical activity?
   Yes/No  If yes, please
   Explain: _________________________________________________________________________

6. Has the child ever been diagnosed with a developmental disorder/ learning disability/ Autism?
   Yes/No  If yes, please
   Explain: _________________________________________________________________________

7. Was the child ever involved in a car accident that resulted in injuries?
   Yes/No  If yes, please
   Explain: _________________________________________________________________________

8. Has the child ever has a head injury, concussion, lost consciousness or memory?
   Yes/No  If yes, please
   Explain: _________________________________________________________________________

9. Has the child suffered any broken or fractured bone(s) or dislocated any joint(s)?
   Yes/No  If yes, please
10. Does the child use any special protective/corrective equipment or medical devices such as glasses, knee/neck brace, shunt, and retainer on the teeth or hearing aid?
   Yes/No
   If yes, please explain:

11. If female, is pregnancy suspected or confirmed? Yes/No
   Due date (if known): ______________________

12. Is Depo Provera injections used for birth control? Yes/No
   If yes, date of the last injection: ______________________

13. Is the child currently taking any prescription or any non-prescription (over-the-counter) medications? Yes/No
   If yes, list all medications that the child is taking at this time, including vitamins:
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ___________________________ ____________________________
   Name of Person completing this Form (Print) Relation to Client
   Signature of Person completing this form Phone Number
Child Specific Staffing Team (CSST) Application

Child’s Name: _______________________________   DOB ___/___/____   Age___________

Parent/Legal Guardian: ______________________________ Phone: _____________________________

Full Address: __________________________________________________________________________

Sex: ____   Race: ________   Ethnicity ____________Does the child have Medicaid?   ___Yes ___No

Name of Florida Medicaid Managed Medical Assistance Program Plan (MMA):
_____________________________________________________________________________________

Medicaid Plan/number ______________   Social Security Number_________________________________

Current Placement (circle or check):  ____ Parent home ____Juvenile Detention Center ___Crisis
Stabilization Unit _____Residential Placement ___Shelter       Adopted ____Yes _____ No

Adoption Agency _______________________________________________

1.) If yes, on what date did the adoption occur? ____________ what state?

2.) Since the adoption, have you received support and or services from an “Adoption’s Preservation
Worker”? ______ Yes ______ No

3.) If so, please provide the contact information

______________________________________________________________________________

4.) Are you receiving an adoption subsidy? _______Yes ______No

5.) If so, list the amount.

6.) Is the child receiving social security benefits? _____ Yes _____ No

7.) If so, please list the amount

8.) Are you receiving any other financial support from any agency, government entity, or other party on
behalf of the adoption? _____Yes ________No

9.) Do you have other adopted children in your home? If so, please describe the age, date of adoption
and financial support provided.

_______________________________________________________________________________
School: ________________________________________________________   Grade: _____________
Current school classification: ______________________________________  Full scale IQ: ________
Diagnosing Clinician/Credentials: ________________________________ Date of DX: __________

**Current Diagnosis**  
Axis I: 
Axis II: 
Axis III: 
Axis IV: 
Axis V: 

**Current Medications/Dosage/Frequency**

Are you involved in Targeted Case Management at this time: Yes _____  No ____
If you are involved in Targeted Case Management who are you receiving services from

Past and current treatment provided (check all applicable):  ____Targeted Case Management  
____Out Patient Counseling  ____Medication  ____TBOS (in-home therapy)  ____Dept. of Juvenile Justice  ____Substance Abuse Treatment  ____Crisis Stabilization

Presenting problems of concern:

_______________________________________________________________

Doctor and/or Clinician’s recommendations:

_______________________________________________________________

Parent Signature: ________________________________ Date: ______________________
Phone: ____________________________
Case Manager/Therapist Signature: ___________________________ Date: ______________________
**Child Specific Staffing Team (CSST) Case Summary**

Child’s Name: ___________________________ Date of Birth: __________________

Child’s strengths:

________________________________________________________________________
________________________________________________________________________

Significant history (i.e. abuse, neglect, exposure to domestic violence, substance abuse, etc.):

________________________________________________________________________
________________________________________________________________________

Current services involved:

________________________________________________________________________
________________________________________________________________________

Medical issues/over the counter medications used regularly:

________________________________________________________________________
________________________________________________________________________

Placements out of home (i.e. residential placement, crisis stabilization admissions):

________________________________________________________________________
________________________________________________________________________

Legal involvement (Dept. of Juvenile Justice and/or Dept. of Children & Families):

1. Has your child had ANY involvement with the criminal justice system? If so, please list the date, charge, and disposition.________________________________________________________

2. Prior to packets being disseminated to providers, parents/guardians will need to contact the DJJ and obtain a copy of the DJJ JJIS form. This form can be obtained from your child’s juvenile probation officer or local detention facility._____________________________________________

3. Please provide the juvenile probation officer’s name and contact information:________________________________________________________
Behavioral symptoms (actions of child):
____________________________________________________________________________

Family issues/supports:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

What parents/guardian is requesting:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Signature of person completing summary: _________________________________________
Relationship to child: __________________________________________________________
Date: _______________________________________________________________________

Parent/Legal Guardian Authorization for the Release of Information

Name of Child: _______________________________________ Date of Birth: __________________________

I (We) hereby authorize ________________________________________ to release a copy of the information specified below:

(Agency name)

[ ] School Records [ ] Department of Juvenile

[ ] Medical History (physical and lab work) [ ] Records of intervention

[ ] Psychiatric/Psychosocial evaluations and information [ ] Clinical Records

[ ] Hospital Records – psychiatric [ ] other(s) Please describe: ________________

[ ] Neurological evaluation

TO THE AGENCY/CSST FACILITATOR CHECKED BELOW & THE MEMBERS OF THE CSST:

[ ] Pasco County: [ ] Sarasota & Desoto Counties: [ ] Charlotte County:

ATTN: Teri Turza ATTN: Erica Barker ATTN: Gina Wynn
BayCare Behavioral Health Coastal Behavioral Health Charlotte Behavioral Health Care
Phone: (727) 315-8862 Phone: (941) 492-4300 Phone: (941) 639-6300 ext. 2497
Fax: (727) 834-3969 Fax: (941) 492-2170 Fax: (941) 639-6831

[ ] Hillsborough County: [ ] Lee County: [ ] CFBHN:

ATTN: Jennifer Fitzgerald ATTN: Salvatore Romano ATTN: Tiffani Fritzsche
CFBHN SalusCare Inc. Peace River Center
Phone: (813) 740-4811 ext. 260 Phone: (239) 275-3222 Phone: (813) 740-4811
Fax: (813) 740-4821 Fax: (239) 989-2891 Fax: (813) 740-4821

[ ] Manatee County: [ ] Pinellas County: [ ] Hardee, Highland, and Polk

ATTN: Charles Whitfield ATTN: Kelly Robbins ATTN: Tiffani Fritzschte
Centerstone Directions for Living Peace River Center
Phone: 941-782-4203 Phone: (727) 748 - 2294 Phone: (863) 519 – 0575, ext. 6235
Fax: (941) 782-4112 Fax (727) 547-4599 Fax (863) 863-519-0528

[ ] Collier County: [ ] Winter Haven Hospital

ATTN: Karen Buckner ATTN: Maureen McIntire
David Lawrence Center Phone: (863) 293-1121
Phone 239 595 - 8479 Other _________________
Fax #239 643-7278

FOR THE PURPOSE OF: Determination of the most appropriate community services and/or residential treatment for the above child and for the approval of funding for recommended treatment. I understand that the information obtained will become part of the application for referral of the above-named child to CSST. If the committee determines that the child is appropriate for a referral to a residential treatment facility and/or community services, I understand that the complete application and packet of records will be forwarded by Central Florida Behavioral Health Inc. to any/all facilities recommended by the committee for consideration for that program.

This release is valid for one (1) year from the date of consent. I understand that consent may be revoked through written request at any time. I have read, or have had verbally explained to me, the above authorization and fully understand it. I hereby, release Central Florida Behavioral Health Inc. and CSST from any liability that may arise as a result of the use of the information contained in the records released.

Signature of Legal Guardian: _______________________________________ Date: __________________________

Relationship to Child: _____________________________________________

Signature of Witness: _____________________________________________

Date: __________________________

719 South US Highway 301, Tampa, FL 33619 • phone: 813-740-4811 fax: 813-740-4821 • www.cfbhn.org
Parent/Legal Guardian Authorization for the Release of Information to Florida Managed Medical Assistance Program (MMA) for Children with Medicaid

Name of Child: ____________________________________________ Date of Birth: __________________

I (We) hereby authorize Central Florida Behavioral Health Network, Inc. to release a copy of the information specified below:

[ ] School Records [ ] Department of Juvenile
[ ] Medical History (physical and lab work) [ ] Records of intervention
[ ] Psychiatric/Psychosocial evaluations and information [ ] Clinical Records
[ ] Hospital Records – psychiatric [ ] other(s) Please describe: ________________

_____________________________ __________________
[ ] Neurological evaluation

TO: Florida Medicaid Managed Medical Assistance Program (MMA) Plan below:

[ ] Amerigroup Florida, Inc. [ ] Better Health [ ] Integral [ ] Humana [ ] Prestige [ ] Sunshine
[ ] United [ ] Molina [ ] Staywell [ ] Psychcare [ ] WellCare [ ] Cenpatico

FOR THE PURPOSE OF: Determination of the most appropriate community services and/or residential treatment for the above child and for the approval of funding for recommended treatment.

I understand that the information obtained will become part of the application for referral of the above-named child to CSST. If the committee determines that the child is appropriate for a referral to a residential treatment facility and/or community services, I understand that the complete application and packet of records will be forwarded by the Central Florida Behavioral Health Inc. to any/all facilities recommended by the committee for consideration for that program.

This release is valid for one (1) year from the date of consent. I understand that consent may be revoked through written request at any time. I have read, or have had verbally explained to me, the above authorization and fully understand it. I hereby, release Central Florida Behavioral Health Network Inc. and CSST from any liability that may arise as a result of the use of the information contained in the records released.

Signature of Legal Guardian: _______________________________ Date: __________________

Relationship to Child: ___________________________________________________________________________

Signature of Witness: _______________________________ Date: __________________
Parent/Legal Guardian General Authorization for the Release of Information

Name of Child: _______________________________________      Date of Birth: __________________

I (We) hereby authorize Central Florida Behavioral Health Network _ to release a copy of the information
(Agency Name)

Specified below:

[ ] School Records      [ ] Department of Juvenile
[ ] Medical History (physical and lab work)   [ ] Records of intervention
[ ] Psychiatric/Psychosocial evaluations and information [ ] Clinical Records
[ ] Hospital Records – psychiatric      [ ] other(s) Please describe
[ ] Neurological evaluation

TO:  Name of Individual and relationship to Parent/Legal Guardian Below _________________________
____________________________________________________________________________________

FOR THE PURPOSE OF: Determination of the most appropriate community services and/or residential

FOR THE PURPOSE OF: Determination of the most appropriate community services and/or residential
treatment for the above child. This release is valid for one (1) year from the date of consent. I understand that
treatment for the above child. This release is valid for one (1) year from the date of consent. I understand that
cconsent may be revoked through written request at any time. I have read, or have had verbally explained to me,
cconsent may be revoked through written request at any time. I have read, or have had verbally explained to me,
the above authorization and fully understand it. I hereby, release Central Florida Behavioral Health Network Inc.
treatment for the above child. This release is valid for one (1) year from the date of consent. I understand that
cconsent may be revoked through written request at any time. I have read, or have had verbally explained to me,
and CSST from any liability that may arise as a result of the use of the information contained in the records
released.

Signature of Legal Guardian: ______________________________    Date: _______________________

Relationship to Child: __________________________________________________________________

Signature of Witness: _________________________________  Date: _____________________

Signature of Legal Guardian: ______________________________    Date: _______________________

Relationship to Child: __________________________________________________________________

Signature of Witness: _________________________________  Date: _____________________
Statement of Dental Stability

Child’s Name: ____________________________  Date of Birth: ________________

Social Security #: _______________________

I, ____________________________________, have examined the above child and have determined that he or she is currently in good physical health with no acute or chronic dental conditions requiring extensive dental treatment, and the need for dental care, other than routine, is not anticipated.

__________________________________________         ___________________
Dentist’s Signature                                                        Date

*** Please attach a copy of the dental records that have been completed within the last 6 months***
*** Only needed for SIPP Services ***
**Statement of Medical Stability**

Child’s Name: _________________________  Date of Birth: ________________

Social Security #: ______________________

I, _________________________ ___________, have examined the above child and have determined that he or she is currently in good physical health with no acute or chronic conditions requiring extensive medical treatment, and the need for medical care, other than routine, is not anticipated.

__________________________________________         ___________________
Physician’s Signature                                    Date

*** Please include last physical exam and any documents that have been completed in the past 90 days. This document cannot be over 12 months/1 year old. ***

*** Only needed for SIPP Services ***
Consent to Release Confidential Information

I, hereby, give my permission to the Central Florida Behavioral Health Network, Inc. to release a copy for the documents presented to the Children’s Services Staffing Team to the agency(ies) recommended by the team for consideration of placement in mental health or substance abuse treatment programs for:

Name of Child: ___________________________

Child’s Date of Birth: ___________________________

I, hereby, release the facility(s) from any liability, which may arise as a result of the use of the information contained in the records released.

___________________________________  _____________________________________
Name of Parent/Guardian     Signature of Parent/Guardian

___________________________________  _____________________________________
Telephone#       Date Signed

Witness:

___________________________________

CFBHN Representative:

 _______________________________________________________________________

TO RECEIVING AGENCY (IES):

PROHIBITON OF REDISCLOSURE: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS FOR WHICH CONFIDENTIALITY IS PROTECTED. ANY FURTHER REDISCLOSURE IS STRICTLY PROHIBITED UNLESS THE CLIENT/GUARDIAN PROVIDES SPECIFIC WRITTEN CONSENT FOR THE SUBSEQUENT DISCLOSURE OF THIS INFORMATION.
Statewide Inpatient Psychiatric Program (SIPP) Contact Information

BayCare SIPP (Pasco County)
Contact: Pete Vlastaras or Mary Galysh
Email: Peter.Vlastaras@baycare.org or Mary.Galysh@baycare.org
8132 King Helie Blvd
New Port Richey, FL 34653
727-834-3965

Palm Shores Behavioral Health Center
(Manatee County)
Contact: Albert Distefano
Email: Albert.Distefano@uhsinc.com
1324 37th Ave E
Bradenton, FL 34210
941-782-1752
□ Has separate unit for children under 12 years old

Sandy Pines (Palm Beach County)
Contact: Meghan Theodore/Joan Kernaghan
Email: Meghan.theodore@uhsinc.com or Joan.kernaghan@uhsinc.com
11301 S.E. Tequesta Terrace
Tequesta, FL 33469
561-744-0211
□ Sexual behavior/trauma issues
□ Spanish speaking program
□ Has separate unit for children under 12 years old

Devereux (Orlando) (Orange County)
Contact: Kelianne Bayless
Email: Referral@devereux.org
6147 Christian Way
Orlando, FL 32808
1-800-338-3738

Florida Palms Academy (Broward County)
Contact: Michelle Thomas or Yadavhi Singh
Email: mthomas@floridapalmsacademy.com or ysingh@floridapalmsacademy.com
5925 McKinley Street
Hollywood, FL 33027
954-963-0992
□ Trauma Resolution Focused Treatment
□ Accepts kids up to 14 years old

Daniel Memorial (Duval County)
Julie Riley
Email: JRiley@danielkids.org
3725 Belfort Road
Jacksonville, FL 32216
904-296-1055 ext, 2371
□ Sexual Reactive Unit

Citrus (Broward/CATS) (Broward County)
Contact: Gisela Suarez or Melissa Guerrero
Email: giselas@citrushealth.com or Melissag@citrushealth.com
8450 South Palm Drive
Pembroke Pines, FL 33025
954-342-0355
□ Ages 13 – 17 years old
□ 1 Pregnant youth at a time
Specialized Therapeutic Group Home (STGH) Contact Information

Carlton Manor (BOYS ONLY) (Pinellas County)
Contact: Dave Hytner
Email: Dhytner@carltonmanor.org
45 Westwood Terrace North
St Pete, FL 33710
727-422-5742

Devereux (Orange County)
Contact: Central Referral Unit (CRU)
Email: Referral@devereux.org
1-800-338-3738, press1, ext. 77130

Boys STGH
1850 South Deleon Ave, Titusville, FL 32780
407-374-1950

Florida United Methodist Children’s Home
Contact: Yolaine Cotel (Volusia County)
Email: Yolaine.Cotel@fumch.org
51 Children’s Way
Enterprise, FL 32725
(386) 668-4774 ext. 2304

**This is a co-ed facility**

Alternative Family Care (GIRLS ONLY)
(Broward County)
Program Coordinator
Yaneque Malcolm 954-599-6561 or 954-680-8462 or ymalcolm@altgroupcare.com
20250 SW 50TH PLACE
Fort Lauderdale, Florida 33332

Program Coordinator
Yaneque Malcolm 954-825-1650 or 954-252-0227 or ymalcolm@altgroupcare.com
5050 SW 163rd Avenue
Fort Lauderdale, FL 33331

St Augustine Youth Services (Saint John’s County)
Contact: Leslie Snyder (BOYS ONLY)
LeslieS@sayskids.org
St. Augustine Youth Services
201 Simone Way,
St. Augustine, FL 32086
(904) 829-1770

Life Stream/Turning Point (GIRLS ONLY)
(Lake County)
Contact: Michele Walsh
Email: M Walsh@lsbc.net
19812 East 5th Street
Umatilla, FL 32784
352-771-8996