Child Specific Staffing Team (CSST) Application Effective February 2020

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).

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Toll-free Helpline: 1-877-711-3662, TTY/TDD users ONLY calls 1-866-467-4970 or visit www.flmedicaidmanagedcare.com. **Call Center Hours: Monday-Thursday 8 am - 8 pm; Friday 8 am - 7 pm. If you need Choice Counseling materials in large print, Audio or Braille, call the Helpline. Si ou bezwen informasion un Kreyol, tanpris rele: 1-877-711-3662.**

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.

<u>**The Following is a list of CAT (Community Action Team) Providers**</u>

1. **Collier County:** David Lawrence Center (239) 455-8500
2. **Hillsborough County**: Gracepoint (813) 239-8453
3. **Lee County**: Centerstone (941) 782-4396
4. **Hendry, Glades County:** Centerstone (941) 782-4396
5. **Manatee County:** Centerstone (941) 782-4396
6. **Sarasota, Desoto Counties:** Centerstone (941) 782-4396
7. **Pinellas County**: Personal Enrichment Through Mental Health Services (727) 362-4255
8. **Polk, Hardee, and Highland Counties:** Peace River Center (863) 519-0575 x 1105
9. **Pasco:** BayCare (727) 315-8638
10. **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

Charlotte County
ATTN: Amy Hood
Charlotte Behavioral Health Care
1700 Education Ave.
Punta Gorda, FL 33950
Phone 941.639.8300 ext. 2490
Fax 941.639.6831
GWynn@cbhcfl.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

Hillsborough County
ATTN: Jennifer Fitzgerald
719 US 301 South
Tampa, FL 33619
Phone 813.740.4811 ext. 260 Fax 813.740.4877
Email: cmh@cfbhn.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

Lee County
ATTN: Stephanie Brooks
SalusCare Inc.
2789 Ortiz Ave
Fort Myers, FL 33905
Phone: 239.322.1561
Fax: 239.425.1524
Mobile: 239-462-5833
E-mail: SBrooks@SalusCareFlorida.org

Pinellas County
ATTN: Jennifer Whealey
Carolee Binette
Directions for Living
8550 Ulmerton Rd. Ste 145 Ave.
Largo, FL 33771
Phone 727.524 – 4464 ext.1943
Fax: 727.507-4006
Email: jwhealey@directionsforliving.org
Cbinette@directionsforliving.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

Polk, Hardee, Highland County
ATTN: Tiffani Fritzsche
Peace River Center
P.O. Box 1559
Bartow, FL 33831-1559
Phone 863.519.0575 ext. 6235
Fax 863-519-0528
mailto:tfritzsche@peacerivercenter.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	Amy Hood	(941) 639-8300 ext. 2490

Collier County

David Lawrence Center	Karen Buckner	(239) 595-8479

Hillsborough County

BNET	Janice Hayes	(813) 239-8222
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) 871-7412 ext. 112 Cell (813) 724-4660.

Lee County

Salus Care	Stephanie Brooks	(239) 322.1561

Manatee County

Centerstone	Charles Whitfield	(941)782-4203

Pinellas County

Adoption Related Services of Pinellas	Email: referral@arsponline.org	(727) 657-7761
Camelot	Ingrid Todd	(813) 635-9765 ext. 33316
Caring Community Counseling	Main Office	(727) 367-2273
Chrysalis Health	Referrals-north@chrysalishealth.com	(727) 231-4885
Directions for Living	Carolee Binette	(727) 547-4566 ext. 4411

Suncoast Region's Children's Mental Health Community Providers Continued

Pinellas County Cont.

PEMHS	Gayle McNeel	(727) 362-4225
Sequel Care of Florida	Kate Malcolm	(727) 547-0607 ext. 116
	Juan Costanza	(727) 547-0607 ext. 123
Suncoast Center for Community Mental Health	Larnetta Peterson	(727) 327-7656 ext. 4161
	Kristen Brundage	(727) 327-7656 ext. 4130

Pasco County

BayCare Behavioral Health	Teri Turza	(727) 315-8862
Caring Community Counseling	Main Office Referrals-	(727)367-2273
Chrysalis Health	north@chrysalishealth.com	(352) 205-4788
Sequel Care of Florida	Sherri Albaum	(727) 422-8431
	Carisa Fleissner	(727) 494-7609
	David Dohm	(727) 494-7609 ext 7003

Sarasota & Desoto Counties

Coastal Behavioral	Erica Barker	(941) 492-4300 ext 2132
Desoto Psychiatric	Crisis 941.575.0222	(941) 639-8300
Providence Human Services of Florida	Counseling/TBOS/Med	(941) 359-1927

Polk, Highlands & Hardee Counties

Chrysalis Health	Referrals- north@chrysalishealth.com	863-216-5636
Peace River Center	Tiffani Fritzsche	(863) 519-0575 ext. 6235
	Donna Rininger	(863) 519-0575 ext. 7298
TriCounty Human Services	Kitty Stark	(863) 452-0106
Winter Haven Hospital	Maureen McIntire	(863) 293-1121

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: ___________

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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 that 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: ____

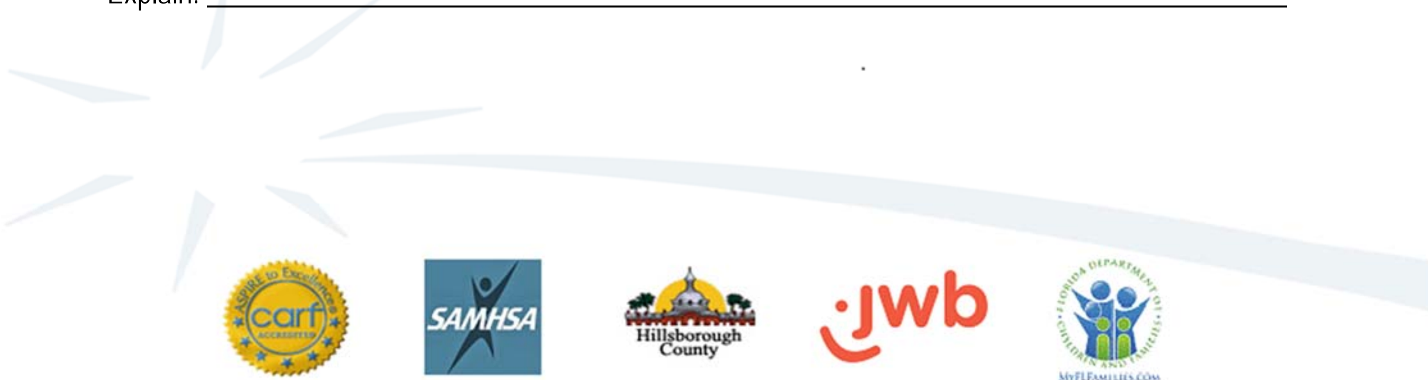
4. Does the child have any active of medical condition or chronic illness? This can include but not limit asthma, seizures, high blood pressure, HIV, Hepatitis B or C, sickle cell, heart disease, diabetes, etc.
   Yes/No If yes, please
   Explain: ____

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
   Explain: ____

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: ________

<u>Current Diagnosis</u>	<u>Current Medications/ Dosage /Frequency</u>
Axis I: ______________________	______________________
Axis II: ______________________	______________________
Axis III: ______________________	______________________
Axis IV: ______________________	______________________
Axis V: ______________________	______________________

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.____

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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
(Agency name)

Specified below:

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

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

[ ] Pasco County:
ATTN: Teri Turza
BayCare Behavioral Health
Phone: (727) 315-8862
Fax: (727) 834-3969

[ ] Hillsborough County:
ATTN: Jennifer Fitzgerald
CFBHN
Phone: (813) 740-4811 ext. 260
Fax: (813) 740-4821

[ ] Manatee County:
ATTN: Charles Whitfield
Centerstone
Phone: 941-782-4203
Fax: (941) 782-4112

[ ] Collier County:
ATTN: Karen Buckner
David Lawrence Center
Phone 239 595 - 8479
Fax #239 643-7278

[ ] Sarasota & Desoto Counties:
ATTN: Erica Barker
Coastal Behavioral Health
Phone: (941) 492-4300
Fax: (941) 492-2170

[ ] Lee County:
ATTN: Stephanie Brooks
SalusCare Inc.
Phone: 239-322-1561
Fax: 239.425-1524

[ ] Pinellas County:
ATTN: Carolee Binette
Directions for Living
Phone: (727) 547-4566 ext. 4411
FAX: (727) 547-4599

[ ] Charlotte County:
ATTN: Amy Hood
Charlotte Behavioral Health Care
Phone: (941) 639-8300 ext. 2490
Fax: (941) 639-6831

[ ] CFBHN:
719 US Highway 301 South
Tampa, FL 33619
Phone: (813) 740-4811

[ ] Hardee, Highland, and Polk
ATTN: Tiffani Fritzsche
Peace River Center
Phone: (863) 519 – 0575, ext. 6235
Fax (863) 863-519-0528

[ ] Winter Haven Hospital
ATTN: Maureen McIntire
Phone: (863) 293-1121
( ) Other ____________

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: ______________________________

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

[ ] Medical History (physical and lab work)

[ ] Psychiatric/Psychosocial evaluations and information

[ ] Hospital Records – psychiatric

[ ] Neurological evaluation

[ ] Department of Juvenile

[ ] Records of intervention

[ ] Clinical Records

[ ] other(s) Please describe: _________________

____

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.

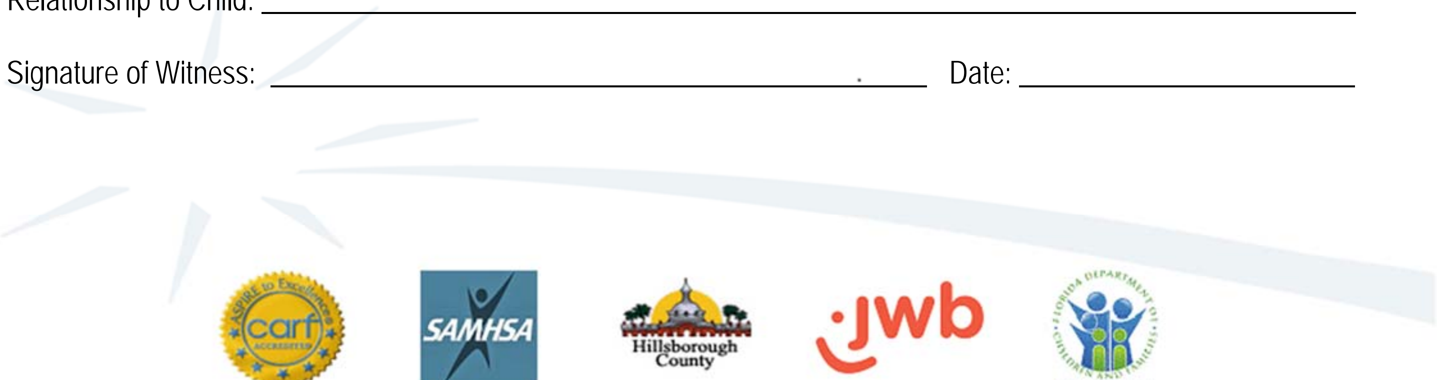
I understand that the information obtained will become part of the application for referral of the above-named child to CSST. If the committee determines that the child is appropriate for a referral to a residential treatment facility and/or community services, I understand that the complete application 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

[ ] Medical History (physical and lab work)

[ ] Psychiatric/Psychosocial evaluations and information

[ ] Hospital Records – psychiatric

[ ] Neurological evaluation

[ ] Department of Juvenile

[ ] Records of intervention

[ ] Clinical Records

[ ] other(s) Please describe ___________________________________

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 treatment for the above child. 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: _____________________

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 ***

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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.*

719 South US Highway 301, Tampa, FL 33619 • phone: 813-740-4811 fax: 813-740-4821 • www.cfbhn.org

Children's Specific Staffing Team (CSST) Targeted Case Management Referral Form

Date: ________________

Child's Name: _______________ DOB: ___________ Medicaid #: _______________

Guardian Contact Name: ____

Address: ____

Phone Number: ____

Current Targeted Case Management Services Information: Write none *in space below if no current TCM Services at this time:*
Agency: __________________________ TCM Name: ______________________Phone: ____________

Contact Information of Person making the request for TCM Services
Name: ____
Address: ____
Phone Number
____

Placement where TCM Services is being requested:
Name of Company:
____
Address: ____
Phone Number____

To be completed by CFBHN's Clinical Program Specialist

Date when referral was made:
____
Additional Comments:
____

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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 Hellie 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: Joan Kernaghan, Marisa Knight
Email: Marisa.Knight@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: Shena Mayas or Michelle Thomas
Email: smayas@floridapalmsacademy.com
mthomas@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)
Contact L 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: SIPPReferrals@citrushealth.com
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
**Only takes CW kids.

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
Anya James 954-599-6561 or 954-680-8462 or
Ajames@altgroupcare.com
20250 SW 50TH PLACE
Fort Lauderdale, Florida 33332

Program Coordinator
Anya James 954-825-1650 or 954-252-0227 or
Ajames@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) in person screening
Contact: Michele Walsh
Email: MWalsh@lsbc.net
19812 East 5th Street
Umatilla, FL 32784
352-771-8996

Child and Family Staffing Summary

Child's Name: ______________________

Medicaid ID: ______________________

Date of Staffing: ______________________

Date of Waive: ______________________

1. Family Invited Attendees (name and relationship):

2. Reason family wants residential mental health treatment for their child in their own words (what benefits they hope their child will get from treatment):

Choice of Program SIPP: 1. ______________ 2. ______________ 3. ______________

TGH: 1. ______________ 2. ______________ 3. ______________

3. Did the team present any available less restrictive treatment options that address the child's identified needs:

Yes ___________ No___________

If yes, what treatment options?

4. If other treatment options were recommended, what were the family's objections or reasons for continuing to request residential mental health treatment services?

5. CFBHN- Additional Notes:

Please Note: While staffing is always a best practice, there are times when caregivers have already gathered all the required information and the necessary referral and choose to waive the staffing. In those cases, please use this form to record the reason why the family chose not to have a staffing (2) and any relevant information you might have about the child and family that would be of help to the UM.