Central Florida Behavioral Health Network, Inc.

Collaborating for Excellence

Child Specific Staffing Team (CSST) Application Effective May 2021

All information should be received prior to a child/family being scheduled for the Child Specific Staffing Team (CSST) staffing. Incomplete information may delay a child/family from being placed on the schedule.

A completed packet with supporting documentation must be sent to the CFBHN CSST Facilitator prior to a CSST staffing being scheduled. Upon receipt of the complete packet, the CFBHN CSST facilitator will provide the scheduling information 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.

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. 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).

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.

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**: 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.

Children's Targeted Case Management Agencies (TCM) by County

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 & DeSoto Counties
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: Gemma Clayson
Charles Whitfield
Centerstone
371 Sixth Ave. West
Bradenton, FL 34205
Phone 941.782.4236 Fax 941.782.4112
Email: Gemma.Clayson@centerstone.org
Charles.whitfield@centerstone.org

Hillsborough County
719 US 301 South
Tampa, FL 33619
Phone 813.740.4811 Fax 813.740.4877
Email: cmh@cfbhn.org

Pasco County
ATTN: Teri Turza, Program Coordinator,
Children's Targeted Case Management
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: 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: Cbinette@directionsforliving.org

Sarasota County
ATTN: Erica Barker
First Step of Sarasota
12497 Tamiami Trail, North Port, FL
34236
Phone 941.331.2530 ext. 4404
EBarker@fsos.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 863.733.4491
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 & DeSoto Counties		
Charlotte Behavioral Health Care	Amy Hood	(941) 639-8300 ext. 2490
Collier County		
David Lawrence Center	Karen Buckner	(239) 595-8479
Hillsborough County		
Caring Community Counseling	Main Office	(727) 367-2273
CFBHN **(For Staffings Only)**		(813) 740-4811
Chrysalis Health	Hillsborough Office	(813) 443-4827
Success 4 Kids & Families		(813) 871-7412 ext. 112 Cell (813) 724-4660.
Lee County		
Salus Care	Stephanie Brooks	(239) 322.1561
Manatee County		
Centerstone	Gemma Clayson	(941)782-4236
	Charles Whitfield	(941)782-4203
Pinellas County		
Family Enrichment Services	Email: referral@arsponline.org	(727) 657-7761
Camelot Community Care	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
Suncoast Center for Community Mental Health	Kristen Brundage	(727) 327-7656 ext. 4161

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

Sarasota County

First Step of Sarasota	Erica Barker	(941) 331-2530 ext 4404
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	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: _____

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: _____

Current Diagnosis	**Current Medications/ Dosage /Frequency**
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._____

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 CHECKED BELOW & THE MEMBERS OF THE CSST:

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

[ ] Sarasota County:
ATTN: Erica Barker
First Step of Sarasona
Phone: (941) 331-2530
Fax: (833) 375-4144

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

[ ] Hillsborough County:

CFBHN
Phone: (813) 740-4811
Fax: (813) 740-4821

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

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

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

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

[ ] Hardee, Highland, and Polk
ATTN: Tiffani Fritzsche
Peace River Center
Phone: (863) 519 – 0575, ext. 6235
Fax: (863) 733-4491

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

[ ] 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 ***

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.*

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:
_____

Statewide Inpatient Psychiatric Program (SIPP) Contact Information

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

- Ages 11-17

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

- Ages 11 - 17

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
321-775-6422 ext. 176422

Florida Palms Academy (Broward County)
Contact: or Michelle Thomas
Email: 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
Email: SIPPReferrals@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

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
(GIRLS ONLY)
51 Children's Way
Enterprise, FL 32725
(386) 668-4774 ext. 2304

St Augustine Youth Services (Saint John's County)
Contact: Marcus Folkes (BOYS ONLY)
MarcusF@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: Christine Powell
Email: CPowell@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: _____

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.