Central Florida Behavioral Health Network, Inc.

Collaborating for Excellence

Child Specific Staffing Team (CSST) Application Effective January 2026

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 Plan (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's Florida Managed Medical Assistance (MMA) Plan prior to admission and the MMA plan will determine the length of stay through its utilization management department with each residential service provider. The CSST application must be sent to the MMA Plan. Please contact below helpline for further information and/or assistance on Florida Managed Medical Assistance (MMA) Plans.

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

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.

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 Community Action Team (CAT) providers:

1. **Collier County:** David Lawrence Center (239) 455-8500
2. **Hillsborough County**: Ibis (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**: Eleos (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 by County

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

Collier County
David Lawrence Center
6075 Bathey Lane
Naples, FL 34116
Phone 239.354.1477
Fax 239-643.7278
ATTN: Karen Buckner, LCSW
KARENB@dlcmhc.com

Charlotte & DeSoto Counties
Charlotte Behavioral Health Care
1700 Education Ave.
Punta Gorda, FL 33950
Phone: 941.875.5258
Fax 941.575.5109
ATTN: Sandra Prince
SPrince@cbhcfl.org

Manatee County
Centerstone
371 Sixth Ave. West
Bradenton, FL 34205
Phone 941.782.4236
Fax 941.782.4112
ATTN: Gemma Clayson and/or
Charles Whitfield
Gemma.Clayson@centerstone.org
Charles.whitfield@centerstone.org

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

Lee County
SalusCare Inc.
2789 Ortiz Ave
Fort Myers, FL 33905
Phone: 239.322.1561
Fax: 239.425.1524
Mobile: 239.560.5276
ATTN: Jennifer Files
JFiles@SalusCareFlorida.org

Pinellas County
Directions for Living
8550 Ulmerton Rd. Suite 145 Ave.
Largo, FL 33771
Phone 727.524.4464 ext.1943
Fax: 727.507.4006
ATTN: Carolee Binette
Cbinette@directionsforliving.org

Polk, Hardee, Highland County
Peace River Center
P.O. Box 1559
Bartow, FL 33831-1559
Phone 863.519.0575 ext.7300
Fax 863.733.4497
ATTN: Ashley Chapman
Ashley.Chapman@peacerivercenter.org

Pasco County
BayCare Behavioral Health
Phone 727.315.8862
ATTN: Teri Turza
Therese.turza@baycare.org

Suncoast Region's Children's Mental Health Community Providers

Charlotte & DeSoto Counties

Charlotte Behavioral Health Care	Main Office	(941) 639-8300
	Crisis Unit	(941) 575-0222

Collier County

David Lawrence Center	Main Office	(239) 595-8479

Hillsborough County

CFBHN **(Staffings Only)**	Main Office	(813) 740-4811
Caring Community Counseling	Main Office	(727) 367-2273
Success 4 Kids & Families	Main Office	(813) 871-7412
Children's Home Society	Main Office	(407) 896-2323
Chrysalis Health	Main Office	(352) 415-5893

Lee County

SalusCare	Main Office	(239) 322.1561
Charlotte Behavioral Health Care	Main Office	(941) 639-8300

Manatee County

Centerstone	Main Office	(941) 782-423

Pinellas County

Camelot Community Care	Main Office	(813) 635-9765
Caring Community Counseling	Pinellas Office	(727) 367-2273
Chrysalis Health	Pinellas Office	(727) 231-4885
Directions for Living	Main Office	(727) 547-4566
Eleos	Main Office	(727) 362-4225
Sequel Care of Florida	Main Office	(727) 547-0607
Suncoast Center for Community Mental Health	Main Office	(727) 327-7656
Family Enrichment Services	Main Office	(727) 657-7761

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

Pasco County

BayCare Behavioral Health	Main Office	(727) 315-8862
Caring Community Counseling	Pasco Office	(727) 367-2273
Chrysalis Health	Pasco Office	(352) 205-4788
Sequel Care of Florida	Main Office	(727) 422-8431

Sarasota County

First Step of Sarasota	Main Office	(941) 331-2530

Polk, Highlands & Hardee Counties

Chrysalis Health	Polk Office	(863) 216-5636
Peace River Center	Main Office	(863) 519-0575
Tri-County Human Services	Main Office	(863) 452-0106
BayCare Behavioral Health	Main Office	(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 submitting 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 items 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 Statewide Inpatient Psychiatric Program or Specialized Therapeutic Group Home level of care based on above criteria. The letter must be written within 90 days of application submission, include the criteria stated above, and how that level of care will benefit the child.**

☐ **Previous Clinical Service Records**

- Outpatient mental health treatment service records, Baker Act records (i.e., admission reports, evaluations, discharge summaries), Residential & Inpatient Admissions, Partial Hospitalizations, or any other relevant treatment service records

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

☐ **School Records**

- Recent report cards, IEP, Section 504 Plan, and recent IQ Score with supported documentation, etc.

☐ **Copy of Birth Certificate and Social Security Card**

☐ **Immunization Record**

☐ **Medical Stability Clearance**

- Please include **physical exam form** within last 90 days and any **medical records** that would be pertinent to treatment

☐ **Dental Clearance**

- Please include last dental service records within the past 6 months or supporting documentation

☐ **DJJ JJIS History Form (If Applicable)**

- **JPO Name**_____ **Phone #** _____

☐ **Identification of a Targeted Case Manager (TCM) in Parent/Guardian County**

- **TCM Agency:**_____
- **TCM Name**_____ **Phone #** _____
- **Adoption Related Specialist:** _____

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: _____

Email Address: _____

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 of Child: **[ ]** Parent/Guardian home **[ ]** Juvenile Detention Center

[ ] Crisis Stabilization Unit **[ ]** Residential Placement **[ ]** Shelter

Is the child adopted? _____ **Yes** _____ **No**

1. If yes, what is the adoption agency? _____
2. If yes, on what date did the adoption occur? _____ State? _____
3. Since the adoption, have you received support and or services from an "Adoption's Preservation Worker"? _____ **Yes** _____**No**
4. If yes, please provide the contact information:
   _____
5. Are you receiving an adoption subsidy? _____**Yes** _____**No**
6. If yes, please list amount: _____
7. Is the child receiving social security benefits? _____**Yes** _____**No**
8. If yes, please list amount: _____
9. Are you receiving any other financial support from any agency, government entity, or other party on behalf of the adoption? _____**Yes** _____**No**
10. 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:	

Is the child involved in Targeted Case Management at this time? _____**Yes** _____**No**

1. If yes, please provide the name of the TCM agency:

_____

Past and current treatment provided (check all applicable): **[ ]** Targeted Case Management

[ ] Outpatient Counseling **[ ]** Medication Management **[ ]** TBOS (in-home therapy)

[ ] Community Action Team **[ ]** DJJ **[ ]** Substance Abuse Treatment

[ ] Crisis Stabilization (_____# of CSU admissions)

Presenting problems of concern**:**

_____

Doctor and/or Clinician's recommendations:

_____

Parent Signature: _____ Date: _____

Phone: _____ Email: _____

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):

_____

_____

Behavioral symptoms (actions of the child):

_____

_____

Family issues/supports:

_____

_____

What parents/guardians are requesting:

_____

_____

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

Has your child had ANY involvement with the criminal justice system? _____Yes _____No

a. If yes, please list the date, charge, and disposition:

_____

b. Please provide the juvenile probation officer's name and contact information:

_____

*Before packets are disseminated to providers, parents/guardians must 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.

Residential program of choice: *please reference pages 21-22 for available programs*

SIPP: 1._____ 2. _____ 3. _____

STGH: 1. _____ 2. _____ 3. _____

Is the staffing being waived? _____Yes _____No

a. If yes, please indicate reason:

_____

_____

Signature of person completing summary: _____

Relationship to child: _____

Date: _____

Email: _____

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/Dental History (physical and lab work)
[ ] Psychiatric/Psychosocial evaluations and information
[ ] Hospital/Psychiatric records
[ ] Other(s): _____
[ ] Department of Juvenile records
[ ] Records of intervention
[ ] Clinical records
[ ] Neurological evaluations

To the Agency & the members of the Child Specific Staffing Team checked below:

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

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

[ ] Charlotte and DeSoto County:
ATTN: Sandra Prince
Charlotte Behavioral Health Care
Phone: (941) 875-5258
Fax: (941) 639-6831

[ ] Hillsborough County:
ATTN: CMH
CFBHN
Phone: (813) 740-4811
Fax: (813) 740-4821

[ ] Lee County:
ATTN: Jennifer Files
SalusCare Inc.
Phone: (239) 322-1561
Fax: (239) 425-1524

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

[ ] 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 County:
ATTN: Ashley Chapman
Peace River Center
Phone: (863) 519-0575, ext. 7300
Fax: (863) 733-4491

[ ] Other _____

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

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 the 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/Dental History (physical and lab work)
[ ] Psychiatric/Psychosocial evaluations and information
[ ] Hospital/Psychiatric records
[ ] Other(s): _____
[ ] Department of Juvenile records
[ ] Records of intervention
[ ] Clinical records
[ ] Neurological evaluations

To: Florida Medicaid Managed Medical Assistance (MMA) Plan checked below:

[ ] Simply Healthcare [ ] Sunshine Health [ ] Magellan [ ] Humana [ ] Beacon [ ] Molina
[ ] Aetna Better Health [ ] United Healthcare [ ] Prestige [ ] CMS [ ] Centene [ ] WellCare
[ ] Staywell [ ] Cenpatico

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

I understand that the information obtained will become part of the application for the 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 had the above authorization verbally explained to me 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, Inc.*** to release a copy of the information
(Agency Name)

Specified below:

[ ] School Records

[ ] Medical/Dental History (physical and lab work)

[ ] Psychiatric/Psychosocial evaluations and information

[ ] Hospital/Psychiatric records

[ ] Other(s): _____

[ ] Department of Juvenile

[ ] Records of intervention

[ ] Clinical Records

[ ] Neurological evaluations

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 determined that he or she is currently in good physical health with no acute or chronic dental conditions requiring extensive dental treatment. 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 of the documents presented to the Children's Specific 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(ies) 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: Megan Holmes and/or Tarrah Clemence
Email: Megan.Holmes@baycare.org
Tarrah.Clemence@baycare.org
8132 King Hellie Blvd
New Port Richey, FL 34653
727-834-3965

- Ages 11-17
- 6th-grade level and above

Palm Shores Behavioral Health Center
(Manatee County)
Email: bradentonrtcreferrals@uhsinc.com
1324 37th Ave E
Bradenton, FL 34210
941-782-1752

- Ages 11-17
- 6th-grade level and above

Sandy Pines (Palm Beach County)
Email: sandypinesreferrals@uhsinc.com
11301 S.E. Tequesta Terrace
Tequesta, FL 33469
561-744-0211

- Sexual behavior/trauma issues
- Spanish-speaking program
- Has a separate unit for children under 12 years old

Devereux (Orange County)
Contact: Kelianne Bayless
Email: Referral@devereux.org
6147 Christian Way
Orlando, FL 32808
321-775-6422 ext. 176422

Gulf Coast (Okaloosa County)
Contact:Terry Abbott
Terry.abbott@uhsinc.com
1015 Mar Walt Dr.
Ft. Walton Beach, Fl. 32547
850-624-2400

- Ages 12-17
- GIRLS ONLY

Palm Point Behavioral Health
(Brevard County)
Email: Palmpointintake@uhsinc.com
2355 Truman Scarborough Way
Titusville, FL 32796
321-603-6550

Florida Palms Academy (Broward County)
Contact: Michelle Thomas
Email: mthomas@floridapalmsacademy.com
5925 McKinley Street
Hollywood, FL 33021
954-963-0991

- Trauma Resolution Focused Treatment
- Ages 6 to 14
- K-8th grade only

Daniel Memorial (Duval County)
Contact: Sa'Mona Mitchell and/or Jessica Tanner
Email: smitchell@danielkids.org
jtanner@danielkids.org
3725 Belfort Road
Jacksonville, FL 32216
904-296-1055 ext. 2371

- Ages 8-17
- Sexual Reactive Unit

Citrus Health Network (Broward County)
Email: SIPPReferrals@citrushealth.com
8450 South Palm Drive
Pembroke Pines, FL 33025
954-342-0355

- Ages 13-17
- 1 Pregnant youth at a time

Suncoast Behavioral Health Center
(Manatee County)
Email: bradentonrtcreferrals@uhsinc.com
4480 51st Street West
Bradenton, FL 34210
941-251-5000 ext. 302

- Ages 12-17
- 6th-grade level and above
- GIRLS ONLY

Brooksville Youth Academy
(Hernando County)
Email: Referrals@youthopportunity.com
201 Culbreath Road
Brooksville, FL 34602
352-504-8911

- Ages 13-17
- BOYS ONLY

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

- **BOYS ONLY**
- *only takes CW kids

Residing Hope/FUMCH
(Volusia County)
Contact: Yolaine Cotel Email:
Yolaine.Cotel@fumch.org or
placements@residinghope.org
51 Children's Way
Enterprise,FL.32725
386-668-4774 ext. 2304

- **GIRLS ONLY**

St Augustine Youth Services
(Saint John's County)
Contact: Kristin Beil or Leslie Snyder
Email: Placement@sayskids.org
St. Augustine Youth Services
201 Simone Way,
St. Augustine, FL 32086

(904) 829-1770

- **BOYS ONLY**

Life Stream/Turning Point
(Lake County)
Contact: Tanya Wilder
Email: TWilder@lsbc.net or
OTPR@LSBC.net
19812 East 5th Street
Umatilla, FL 32784

352-657.9157

- **GIRLS ONLY**
- in-person pre-admission screening required