FAST Referral

Cayuga County
Families Access to Services Team (FAST)

What is FAST?

FAST is a team of providers from Cayuga County Departments of Social Services, Mental Health and Probation, as well as school and community-based agencies. FAST is designed to provide quick access to home and community-based services for families with children who are experiencing significant problems at home or in the community. The team will work in partnership with parents/caretakers and their youth to strengthen and keep families together.

Providers may contact FAST at 315-294-8180 or email FAST at fast@cayugacounty.us for more information.

How to make a referral to FAST:

Service providers may refer a family to FAST by completing the attached form and returning to FAST.

1. Complete consent form and referral
2. Return to FAST at CCCMHC
   Fax: **315-253-1687** *Attn: FAST*
   Mail or drop off: 146 North Street
   Auburn, NY 13021
   Attn: FAST

**Families will be contacted within 5 business days of receiving the referral*

Services available through FAST:

- **Adolescent DBT Skills Group**, *Cayuga County Mental Health Center* (ages 12-15 and 15-18)
- **Functional Family Therapy (FFT**), *Cayuga Centers* (ages 10-18)
- **Health Home Care Management** (under age 19)
- **High Fidelity Wraparound Services (HFW)**, *Cayuga Counseling Services* (ages 12-21)
- **Multisystemic Therapy (MST)**, *Cayuga Centers* (ages 11-18)
- **Parent Partners**, *Cayuga Counseling Services*
- **Restorative Youth Supervision and Collaboration (RYSC)**, *Cayuga Counseling Services*
- **Ready Respite** – *Residential and Community-based* (5-17)
- **SafeCare**, *Cayuga Centers* (Ages 0-5)
- **Triple P**, *Cayuga Counseling* (Ages 2-12)

REQUIRED CONSENT FOR RELEASE OF INFORMATION for FAST

This authorization must be completed by the referred individual or his/her legal guardian to use/disclose Protected Health Information (PHI) in accordance with state and federal laws and regulations that govern the release of confidential records, as well as Title 42 of the Code of Federal Regulations that governs the release of drug & alcohol records. A separate authorization is required to use or disclose confidential HIV information.

CHILD'S NAME: _____ **Child's DOB:** _____

COUNTY(IES): _____

I authorize an exchange of PHI between the FAST Committee AND OTHER AGENCY/PERSON providing information to the committee (Please see attached list of agencies from which the SPOA Committee is permitted to request information):
AND: Referral Source (Person / Title / Agency or School):

_____

Description of information to be used / disclosed is as follows: (Please initial ALL that apply)

- ☐ Referral Packet
- ☐ Diagnosis
- ☐ Financial Status
- ☐ Physical Exam History
- ☐ School Records
- ☐ Physician's Authorization for Restorative Services
- ☐ Psychological & Neurological Tests
- ☐ Discharge Summary / Treatment Plans
- ☐ Psychosocial History & Assessment
- ☐ Inpatient/Outpatient History
- ☐ Psychiatric Assessment
- ☐ Other (progress notes)
- ☐ **ALL**

Purpose or need for information:
By the individual or his/her personal representative to facilitate participation in services through FAST.

Note: If the same information is to be disclosed to multiple parties for the same purpose, for the same period of time, this authorization will apply to all parties listed on the attached list.

Thereby permit the use/disclosure of the indicated PHI to the Person/Organization/Facility/Program identified above. I understand that:

- Only this information may be used/disclosed as a result of this authorization;
- This information is confidential and cannot legally be disclosed or re-disclosed without my permission;
- If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be re-disclosed and would no longer be protected;
- I have the right to take back this authorization at any time. This revocation must be in writing on a form provided by the County government. I am aware that my revocation does not affect information already disclosed because of my earlier authorization;
- Signing this authorization is voluntary and my refusal to sign will not affect treatment, payment, enrollment or eligibility benefits;
- I have the right to inspect and copy my own PHI to be used/disclosed as provided in 45CFR 164.524.

I hereby authorize the periodic use or disclosure of the information described above to the Person/Organization/Facility/Program identified as often as necessary to fulfill the purpose identified above, and this authorization will expire: **(Initial ONE)**

☐ When the child named herein is no longer receiving Services through the FAST program in *(fill in county(ies))*
_____ Counties

☐ One Year from the date below

☐ Other: _____

I hereby authorize the one-time use or disclosure of the information described above to the Person/Organization/Facility/Program identified above and this authorization will expire:

☐ When acted upon

☐ Other: _____

I certify that I authorize the use of the health information as set forth in this document. By signing this authorization, I acknowledge that I have read and understand it. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability from the disclosure of the above information to the extent indicated and authorized herein.

Signature of Parent/Guardian	Date	Relationship
Signature of Client	Date	
Signature of Witness	Date	

- ❑ Copy of Release Given to Client
- ❑ Client Refused Copy of Release

This consent will expire _____

I_____, the parent/guardian of the above child, do hereby consent and authorize information to be obtained from and/or released to: Cayuga County FAST to include representatives from:

- Auburn Community Hospital
- Auburn Enlarged Central School District
- Auburn Police Department
- Auburn Rescue Mission
- Cato Meridian Central School District
- Cayuga Centers
- Cayuga Counseling Services, Inc.
- Cayuga County Community Mental Health Center (CCCMHC)

- Clinic & Care Management

- Cayuga County Health & Social Services –

- Child Protective Services (CPS), Preventive and Foster Care

- Cayuga County Department of Probation
- Cayuga County Sherriff
- Cayuga-Onondaga BOCES
- Cayuga/Seneca Community Action Agency (CSCAA)
- Center for Human Services Research, University at Albany
- Confidential Help for Alcohol & Drugs (CHAD)
- Children's Health Home of Upstate New York (CHHUNY)
- CNYHHN, Inc.
- Encompass Health Home
- Greater Rochester Health Home Network (GRHHN)
- Helio Health
- Hillside Family of Agencies
- Hutchings Psychiatric Center (HPC)
- Jordan-Elbridge Central School District
- Liberty Resources
- Mohawk Valley Psychiatric Center
- Moravia Central School District
- Port Byron Central School District
- Red Creek Central School District
- Salvation Army
- Seneca Cayuga ARC
- Skaneateles Central School District
- Southern Cayuga Central School District
- Union Springs Central School District
- Weedsport Central School District
- Primary Care Physician (write in):_____
- Other (write in): _____

Child's Name	DOB	Gender (Male, Female, Trans, Other)

School District:	Ethnicity:	Race:	Child insured through:
☐Child has an ☐IEP ☐504 ☐BIP (Behavioral Intervention Plan) ☐Child under 5 in home	☐Hispanic/Latino ☐Central American ☐Cuban ☐Dominican ☐Mexican ☐Puerto Rican ☐South American ☐Other:_____	☐Black/African ☐American ☐Asian ☐Native ☐Hawaiian/Pacific Islander ☐White ☐American Indian	☐Medicaid ☐Private Insurance ☐CHIP ☐Other:_____ ☐SSI ☐None ID#_____

Parent/ Guardian/Caretaker Name(s) please print	Relationship	Best Time to Contact

Address	City	Zip

Phone	Alternate Phone

With which of the following agencies is the child involved?

☐Mental Health Agency/Clinic/Provider
☐Physical Health Agency/Clinic/Provider
☐Substance Abuse Health Agency/Clinic/Provider
☐Intellectual Disabilities Health Agency/Clinic/Provider
☐School/Educational Facility/Staff
☐Early Intervention
☐Child Welfare/Child Protective Services
☐Family Court
☐Juvenile Court/Corrections/Probation/Police
☐Caregiver
☐Other:_____

What led to the child being referred for services?

☐**Conduct/delinquency-related behaviors** *(physical aggression, extreme verbal abuse, non-compliance, sexual acting out, property damage, theft, running away, sexual assault, fire setting, cruelty to animals, truancy, police contact)*
☐**Intellectual disabilities**
☐**Hyperactive and attention-related behaviors** *(hyperactivity, impulsive, attentional difficulties)*
☐**School/Educational performance**
☐**Depression** *(major depression, dysthymia, sleep disorders, somatic complaints)*
☐**Anxiety** *(fears and phobias, generalized anxiety, social avoidance, obsessive compulsive behavior, post –traumatic stress disorder)*
☐**Adjustment-related issues** *(changes in behaviors or emotions in reaction to a significant life stress)*
☐**Suicide-related thoughts or actions** *(suicide ideation or suicide attempt)*
☐**Self-injury** *(self-injurious behavior, hair pulling, cutting, etc.)*
☐**Psychotic behaviors** *(hallucinations, delusions, strange or odd behaviors)*
☐**Substance use, abuse and drug dependency behaviors**
☐**Learning disabilities**
☐**Eating disorders** *(anorexia, bulimia)*
☐**Sleeping problems**
☐**Current home unable to meet child's needs**
☐**Maltreatment** *(child abuse and neglect)*
☐**Behavioral concerns** *(aggression, severe defiance, acting out, impulsivity, recklessness, and excessive level of over activity)*
☐**Excessive crying/tantrums**
☐**Persistent noncompliance** *(when directed by caregivers/adults)*
☐**Pervasive developmental disabilities** *(autistic behaviors, extreme social avoidance, stereotypes, perseverative behavior)*
☐**Specific developmental disabilities** *(enuresis, encopresis, expressive or receptive speech and language delay)*
☐**Separation problems**
☐**Feeding problems** *(including failure to thrive)*
☐**Excluded from preschool or childcare due to behavioral or developmental problems**
☐**Attachment problems**
☐**Other concerns/issues that are related to child's health** *(cancer, illness, or disease related problems)*
☐**Other:**_____

What is the child's clinical diagnosis?

	Diagnostic Code	Diagnosis Name
Primary Diagnosis	_____	_____
Secondary Diagnosis	_____	_____
Additional Diagnosis	_____	_____

Date of most recent diagnostic eval: _____ Diagnostic system used: ☐DSM-IV-TR ☐DSM-V ☐ICD-10

Has the child visited the Emergency Room for behavioral issues in the last **90 days**? ☐ Yes ☐ No

Desired Outcome for Services: _____

_____

_____

_____

Family Strengths: _____

_____

_____

_____

Child's Strengths/Interests/Hobbies/Activities: _____

_____

_____

_____

Family's Informal Supports (ex: Relatives, Community Organization, Schools): _____

_____

_____

_____

Family's Service Preference: _____

_____

Additional Info: _____

_____

_____

_____

_____

Which agency/individual is referring the child to the program?

☐Mental Health Agency/Clinic/Provider
☐Physical Health Agency/Clinic/Provider
☐Substance Abuse Health Agency/Clinic/Provider
☐Intellectual Disabilities Health Agency/Clinic/Provider
☐School/Educational Facility/Staff
☐Early Intervention
☐Child Welfare/Child Protective Services
☐Family Court
☐Juvenile Court/Corrections/Probation/Police
☐Caregiver
☐Other:_____

Date of Referral:_____

_____ _____
Person Making Referral **Agency**

_____ _____ _____
Address **City** **Zip**

_____ _____ _____
Phone **Fax** **Email**

FAST Families Assist to Survival Team