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 to 315-253-1687 Attn: FAST
   Mail or drop off at 146 North Street, Auburn, NY 13021 Attn: FAST
3. Family will be contacted within 5 business days from receipt of referral

Services available through FAST:

- Adolescent DBT Skills Group (ages 12-15 and 15-18)
- Functional Family Therapy (FFT), Cayuga Centers (ages 10-18)
- Health Home Care Management (under age 19)
- Home and Community-based Waiver, Hillside Children's Center and Liberty Resources
- Multisystemic Therapy (MST), Cayuga Centers (ages 11-18)
- Parent Partners, Cayuga Counseling Services
- PINS Diversion Services, Cayuga Counseling Services
- Ready Respite – Residential and Community-based (ages 5-17)
- SafeCare, Cayuga Centers (Ages 0-5)
- Triple P, Partnership for Results (Ages 2-12)
- Youth Mentor, Hillside (Ages 14-18)

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MULTIPLE PARTY RELEASE FORM

Cayuga County Families Access to Services Team

Client Name	Date of Birth	Date Revoked	Staff Signature

I, _____, 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
- Cayuga Centers
- Cayuga Counseling Services, Inc.
- Cayuga County Community Mental Health Center (CCCMHC) – Clinic & Care Management
- Cayuga County Community Mental Health Center (CCCMHC) – Intensive Case Management
- Cayuga County Health & Social Services – Child Protective Services (CPS), Preventive and Foster Care
- Cayuga County Department of Probation
- 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)
- Hillside Family of Agencies
- Hutchings Psychiatric Center (HPC)
- Liberty Resources
- Partnership for Results
- Primary Care Physician (write in):_____
- School District (write in): _____
- Seneca Cayuga ARC
- Other (write in): _____

The following information pertaining to my child:

- Drug/Alcohol History
- Medical Records
- Psychiatric Assessment
- Psychological Assessment
- Psychosocial History
- School records (including IEPs, psychological testing, etc.)

PURPOSE OF THE RELEASE:

To complete and process referral; to coordinate services for the family; and ongoing monitoring and assessment by FAST.

I understand that my alcohol/or drug treatment records, when associated with a federally funded alcohol or drug treatment program, are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164. Treatment records from agencies licensed by the NYS Office of Mental Health are protected by Mental Hygiene Law Section 33.13, and by 45 C.F.R. Pts. 160 & 164, and cannot be re-disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically after my child is no longer receiving services under the care of the FAST.

Signature of Parent/Guardian	Date	Relationship

Signature of Client	Date

Signature of Witness	Date

This consent will expire _____

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

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

School District

Child has an
- ☐ IEP
- ☐ 504
- ☐ BIP (Behavioral Intervention Plan)

Ethnicity
- ☐ Hispanic/Latino -
  - ☐ Central American
  - ☐ Cuban
  - ☐ Dominican
  - ☐ Mexican
  - ☐ Puerto Rican
  - ☐ South American
  - ☐ Other _____

Race
- ☐ Black/African American
- ☐ Asian
- ☐ Native Hawaiian/ Pacific Islander
- ☐ Alaska Native
- ☐ White
- ☐ American Indian

Child insured through…?
- ☐ No insurance
- ☐ Medicaid
- ☐ Private Insurance
- ☐ CHIP
- ☐ Other _____
- ☐ SSI

Medicaid/Insurance ID

Parent/Guardian/Caretaker Name(s) ***Please print*** | **Best time to contact** | **Phone Number**

Address | **City** | **Zip**

With which of the following agencies is the child involved?
- ☐ Mental Health Agency/Clinic/Provider
- ☐ Physical Health Care Agency/Clinic/Provider
- ☐ Substance Abuse Agency/Clinic/Provider
- ☐ Intellectual Disabilities 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** _____

Desired Outcome for Services: _____

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Emergency Room for behavioral issues in the last 90 days ☐ Yes ☐ No

Please Describe Family's Strengths: _____

_____

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

_____

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

_____

Family Service Preference: _____

_____

_____ _____ _____ _____

Parent/Guardian Signature **Date** **Child Signature** **Date**

For Service Providers:

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

What is the child's clinical diagnosis?

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

What agency or individual referred the child to the program?

- ☐ Mental Health Agency/Clinic/Provider
- ☐ Physical Health Care Agency/Clinic/Provider
- ☐ Substance Abuse Agency/Clinic/Provider
- ☐ Intellectual Disabilities Agency/Clinic/Provider
- ☐ School/Educational Facility (BOCES)/Staff
- ☐ Early Intervention
- ☐ Child Welfare/Child Protective Services
- ☐ Family Court
- ☐ Juvenile Court/Corrections/Probation/Police
- ☐ Caregiver
- ☐ Youth/Child referred him/herself
- ☐ Other _____

Person/Agency Making Referral: _____ **Phone:** _____

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

Fax: _____ **Email:** _____ **Date of Referral:** _____

_____ _____ _____ _____

Referral Source Signature **Date** **Supervisor Signature** **Date**