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, 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)
- 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
- 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)

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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
- 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 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 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)
- Hillside Family of Agencies
- Hutchings Psychiatric Center (HPC)
- Jordan-Elbridge Central School District
- Liberty Resources
- Moravia Central School District
- Port Byron 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): ______________________________________

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

FAST Referral

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

School District ______

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

☐ Child under 5 in the home?

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 ID (Alpha-Numeric) ______

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** ______

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

 Updated 6/14/18

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Desired Outcome for Services:____

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

Family's Strengths:____

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

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

Family's Service Preference:____

Additional Info:____

What agency/individual is referring 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 Making Referral:____________________ **Date:**__________

Agency:____________________ **Phone:**__________

Address:____________________ **City:**__________ **Zip:**__________

Fax:__________ **Email:**____________________ **Date of Referral:**__________

____________________	__________	____________________	__________
Parent/Guardian Signature	**Date**	**Child Signature**	**Date**
Referral Source Signature	**Date**	**Referral Source Supervisor Signature**	**Date**

Updated 6/14/18