

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)
- 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)
- Youth Mentor, Hillside (Ages 14-18)

FAST Referral
MULTIPLE PARTY RELEASE FORM
Cayuga County Families Access to Services Team

Client Name	Date of Birth	Date Revoked	Staff Signature
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I, _____, do hereby consent and authorize information to be obtained from and/or released to: Cayuga County FAST to include representatives from:

- | | |
|---|--|
| <ul style="list-style-type: none"> Auburn Community Hospital Auburn Enlarged Central School District Cayuga Centers Cayuga Counseling Services, Inc. Cayuga County Community Mental Health Center (CCCMHC) <ul style="list-style-type: none"> – Clinic & Care Management Cayuga County Community Mental Health Center (CCCMHC) <ul style="list-style-type: none"> – Intensive Case Management Cayuga County Health & Social Services – <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> 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

FAST Referral

Child's Name _____		DOB _____	Gender (Male, Female, Trans, Other) _____												
School District _____ Child has an <input type="checkbox"/> IEP <input type="checkbox"/> 504 <input type="checkbox"/> BIP (Behavioral Intervention Plan)	Ethnicity <input type="checkbox"/> Hispanic/Latino - <input type="checkbox"/> Central American <input type="checkbox"/> Cuban <input type="checkbox"/> Dominican <input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> South American <input type="checkbox"/> Other _____	Race <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/ Pacific Islander <input type="checkbox"/> Alaska Native <input type="checkbox"/> White <input type="checkbox"/> American Indian	Child insured through...? <input type="checkbox"/> No insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance <input type="checkbox"/> CHIP <input type="checkbox"/> Other _____ <input type="checkbox"/> SSI Medicaid ID (Alpha-Numeric) _____												
Parent/Guardian/Caretaker Name(s) <i>Please print</i> _____		Best time to contact _____	Phone Number _____												
Address _____		City _____	Zip _____												
With which of the following agencies is the child involved? <div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <input type="checkbox"/> Mental Health Agency/Clinic/Provider <input type="checkbox"/> Physical Health Care Agency/Clinic/Provider <input type="checkbox"/> Substance Abuse Agency/Clinic/Provider <input type="checkbox"/> Intellectual Disabilities Agency/Clinic/Provider <input type="checkbox"/> School/Educational Facility/Staff <input type="checkbox"/> Early Intervention </div> <div style="width: 48%;"> <input type="checkbox"/> Child Welfare/Child Protective Services <input type="checkbox"/> Family Court <input type="checkbox"/> Juvenile Court/Corrections/Probation/Police <input type="checkbox"/> Caregiver <input type="checkbox"/> Other _____ </div> </div>															
What led to the child being referred for services? <div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <input type="checkbox"/> 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) <input type="checkbox"/> Intellectual disabilities <input type="checkbox"/> Hyperactive and attention-related behaviors (hyperactivity, impulsive, attentional difficulties) <input type="checkbox"/> School/Educational performance <input type="checkbox"/> Depression (major depression, dysthymia, sleep disorders, somatic complaints) <input type="checkbox"/> Anxiety (fears and phobias, generalized anxiety, social avoidance, obsessive compulsive behavior, post-traumatic stress disorder) <input type="checkbox"/> Adjustment-related issues (changes in behaviors or emotions in reaction to a significant life stress) <input type="checkbox"/> Suicide-related thoughts or actions (suicide ideation or suicide attempt) <input type="checkbox"/> Self-injury (self-injurious behavior, hair pulling, cutting, etc.) <input type="checkbox"/> Psychotic behaviors (hallucinations, delusions, strange or odd behaviors) <input type="checkbox"/> Substance use, abuse and drug dependency behaviors <input type="checkbox"/> Learning disabilities </div> <div style="width: 48%;"> <input type="checkbox"/> Eating disorders (anorexia, bulimia) <input type="checkbox"/> Sleeping problems <input type="checkbox"/> Current home unable to meet child's needs <input type="checkbox"/> Maltreatment (child abuse and neglect) <input type="checkbox"/> Behavioral concerns (aggression, severe defiance, acting out, impulsivity, recklessness, and excessive level of over activity) <input type="checkbox"/> Excessive crying/tantrums <input type="checkbox"/> Persistent noncompliance (when directed by caregivers/adults) <input type="checkbox"/> Pervasive developmental disabilities (autistic behaviors, extreme social avoidance, stereotypes, perseverative behavior) <input type="checkbox"/> Specific developmental disabilities (enuresis, encopresis, expressive or receptive speech and language delay) <input type="checkbox"/> Separation problems <input type="checkbox"/> Feeding problems (including failure to thrive) <input type="checkbox"/> Excluded from preschool or childcare due to behavioral or developmental problems <input type="checkbox"/> Attachment problems <input type="checkbox"/> Other concerns/issues that are related to child's health (cancer, illness, or disease related problems) <input type="checkbox"/> Other _____ </div> </div>															
What is the child's clinical diagnosis? <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;"></th> <th style="width: 30%; text-align: center;">Diagnostic Code</th> <th style="width: 40%; text-align: center;">Diagnosis Name</th> </tr> </thead> <tbody> <tr> <td>Primary Diagnosis</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Secondary Diagnosis</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Additional Diagnosis</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table> <p>Date of most recent diagnostic eval _____ Diagnostic system used: <input type="checkbox"/> DSM-IV-TR <input type="checkbox"/> DSM-V <input type="checkbox"/> ICD-10</p>					Diagnostic Code	Diagnosis Name	Primary Diagnosis	_____	_____	Secondary Diagnosis	_____	_____	Additional Diagnosis	_____	_____
	Diagnostic Code	Diagnosis Name													
Primary Diagnosis	_____	_____													
Secondary Diagnosis	_____	_____													
Additional Diagnosis	_____	_____													

FAST Referral

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?

- | | |
|---|--|
| <input type="checkbox"/> Mental Health Agency/Clinic/Provider | <input type="checkbox"/> Child Welfare/Child Protective Services |
| <input type="checkbox"/> Physical Health Care Agency/Clinic/Provider | <input type="checkbox"/> Family Court |
| <input type="checkbox"/> Substance Abuse Agency/Clinic/Provider | <input type="checkbox"/> Juvenile Court/Corrections/Probation/Police |
| <input type="checkbox"/> Intellectual Disabilities Agency/Clinic/Provider | <input type="checkbox"/> Caregiver |
| <input type="checkbox"/> School/Educational Facility (BOCES)/Staff | <input type="checkbox"/> Youth/Child referred him/herself |
| <input type="checkbox"/> Early Intervention | <input type="checkbox"/> 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