Madera County Child & Family Team (CFT) Meeting

REVIEW DATE:

NEXT MEETING DATE:________

Name: ________________________

Attendees: ____

____

Family driven plan:

Strengths	Needs	Plan & by When?	Who's Responsible

Sign in Sheet Madera County - CHILD & FAMILY team Meeting

Understanding of Confidentiality

We will be discussing some sensitive issues and ask that you respect the family's right to privacy. It is important that you agree to abide by the rules of confidentiality. Information about minor children is confidential by law. Anything discussed during the meeting must **NOT** be repeated, either directly or indirectly, outside of the meeting, except by BHS staff, DSS staff and service providers in the course of implementing the plan and reporting to the Court.

At the Child/Family Treatment Team Meeting on ___________(date), the following individuals were present and had the opportunity to provide input into the development of this Summary of Findings Report. Attendance and the agreement to the confidentiality statement are confirmed by the signature of the individuals on this document.

PARTICIPANTS

Name (Please Print)	***Phone Number And /Or Email Address***	***Title/Relationship to the Child***

MENTAL HEALTH SCREENING TOOL
(CHILD 0-5 YEARS)

CHILD NAME:____ **DATE:**______________________

DATE OF BIRTH:_____________ **BHS CLIENT#:**______________

REFERRING SOCIAL WORKER:____

BIO MOTHER PARTICIPATED IN ASSESSMENT □YES □NO

BIO FATHER PARTICIPATED IN ASSESSMENT □YES □NO

BIO PARENT SCHEDULED FOR MH ASSESSMENT □YES □NO

If yes, date, place, clinician:____

NO SHOW FOR SCHEDULED MH ASSESSMENT □YES □NO

If yes, date, place, clinician:____

MEDICAL NECESSITY FOR MH TREATMENT □YES □NO

KATIE A. CLASS □YES □NO

KATIE A. SUBCLASS □YES □NO

□**CHILD WILL BE OPENED FOR TREATMENT WITH**____
____

□ **CHILD DOES NOT MEET MEDICAL NECESSITY FOR MH TREATMENT AT THIS TIME**

COMMENTS:

____
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____
____
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____

Respectfully Submitted,

___________________________________ ________________

Art A. Galindo, LCSW Date
Clinical Supervisor, Lake Street Center
Madera County Behavioral Health Services

MENTAL HEALTH SCREENING TOOL

(CHILD 5 YEARS TO ADULT)

CHILD NAME:____ DATE:______________________

DATE OF BIRTH:_____________ BHS CLIENT#:______________

REFERRING SOCIAL WORKER:____

BIO MOTHER PARTICIPATED IN ASSESSMENT	**□YES**	**□NO**
BIO FATHER PARTICIPATED IN ASSESSMENT	**□YES**	**□NO**
BIO PARENT SCHEDULED FOR MH ASSESSMENT	**□YES**	**□NO**

If yes, date, place, clinician:____

NO SHOW FOR SCHEDULED MH ASSESSMENT	**□YES**	**□NO**

If yes, date, place, clinician:____

MEDICAL NECESSITY FOR MH TREATMENT	**□YES**	**□NO**
KATIE A. CLASS	**□YES**	**□NO**
KATIE A. SUBCLASS	**□YES**	**□NO**

□CHILD WILL BE OPENED FOR TREATMENT WITH____

____

□ CHILD DOES NOT MEET MEDICAL NECESSITY FOR MH TREATMENT AT THIS TIME

COMMENTS:

____

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____

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Respectfully Submitted,

______________________________ ______________

Art A. Galindo, LCSW Date
Clinical Supervisor, Lake Street Center
Madera County Behavioral Health Services

MCDSS Katie A. Sub-Class Eligibility Assessment/Referral Form for BHS Services

Section I DSS Case Managing Social Worker Completes

Child Referred Date of Birth: SSN:

Date Social Worker Initiated referral: Social Worker: Phone Number:

Initial ☐ Six Month ☐ Annual ☐ Unscheduled ☐ Date Opened to CWS:

IDENTIFYING INFORMATION:

Childs Preferred Language: Ethnicity:

Current Residence: Shelter☐ Group Home ☐ Relative☐ Foster Care☐ Home☐ Other☐ _____________________

Name of minor's current substitute care provider: Phone#:

Address:

Case Name (mother/legal guardian): CWS Case#:

Has Child had three or more placements with 24 months due to behavioral health concerns? Yes ☐ No ☐

Program Component: ☐ ER ☐ Court FM ☐ VFM ☐ FR ☐ PP ☐ Adoptions

Names of Parents/Legal Guardians: Phone#:

Approved to Participate in Childs Treatment Plan: Yes ☐ No ☐

Address:

Current Mental Health Services? Yes ☐ No ☐ Agency/Clinic: ______________________________ Telephone:_______

Is Child a Regional Center Client? Yes ☐ No ☐ Name of Case Worker: _________________________ Telephone::________

Currently Enrolled in School? Yes ☐ No ☐ Name of School: _________________________ Grade: ______

ATTACHMENTS: ☐ Consent for General Treatment ☐ Authorization to Release Information

Section II to be completed by DSS Katie A Coordinator

Date Sent to BHS Katie A Coordinator: ______________ DSS Katie A Coordinator: (initials) __________

Section III to be completed by BHS Katie A Coordinator Date Received: __________

SUBCLASS ELIGIBILITY CRITERIA:

1. Does the above mentioned child have full-scope Medi-Cal? Yes ☐ No ☐
2. Is the above mentioned child already receiving or been referred to a mental health clinic? Yes ☐ No ☐
   If yes, name of clinic: Name of assigned therapist:
3. Is the child currently receiving or being considered for any of the following services: Yes ☐ No ☐

If yes, select at least one of the following boxes:	Currently receiving service	Being considered for the service
Wraparound	☐	☐
Intensive Therapeutic Foster Care (ITFC)	☐	☐
Specialized Care Rate due to behavioral health needs	☐	☐
Therapeutic Behavioral Services	☐	☐
Crisis Intervention	☐	☐
Other intensive EPSDT services	☐	☐
Placement in an RCL 10 or above facility	☐	☐
Psychotropic Medication	☐	☐
Placement in a Psychiatric hospital (e.g., 5150)	☐	☐

See Previous Page for response to Question 4.

4. Has the child had three or more placements within 24 months due to behavioral health concerns? Yes ☐ No ☐

Child's current living situation: Shelter☐ Group Home ☐ Relative☐ Foster Care☐ Home☐ Other☐ _____________

Below to be completed by BHS Katie A. Coordinator

Initial assessment – 1st Quarter	180 day re-assessment	Yearly re-assessment
Child meets Katie A class criteria: ____yes ____no	Child meets Katie A class criteria: ____yes ____no	Child meets Katie A class criteria: ____yes ____no

Initial assessment – 1st Quarter	180 day re-assessment	Yearly re-assessment
Child meets Katie A sub-class criteria: ____yes ____no	Child meets Katie A sub-class criteria: ____yes ____no	Child meets Katie A sub-class criteria: ____yes ____no

Child meets medical necessity Criteria? Yes ☐ No ☐

Child referred to mental health clinic? Yes ☐ No ☐

If yes, name of clinic: ____________________________ Date referred:__________

Date of first appointment: _____

☐ Completed referral and attachments approved by BHS Katie A. Coordinator:

_______________________________________ _____ ______________________________

BHS Katie A. Coordinator Name (*Please Print*) Date Signature

****Children meet criteria for the Katie A. Subclass if:***
*-The answers to numbers **1 and 2** are both "yes" **and** either 3 or 4 are "yes."*

Copy Returned to: DSS Katie A Coordinator____Date:_______________