Intake Services

HIGHER LEVEL OF CARE REFERRAL – PROFESSIONAL

Required Referral Information

****For children in crisis, call Child Priority Response at 1-800-969-4357****

If we receive a complete referral:

- A referral is complete when 1) all items are filled out, 2) there is sufficient clinical information to score a CASII, and if applicable, 3) **Required Supplemental Documentation** is included (see below).
- Complete referrals can be processed within two (2) business days.
- **Service eligibility is determined based on information you provide in this referral**.
    - Please ensure the information you provide is complete, detailed, and accurately describes the child's current emotional/behavioral concerns and functioning.

If we receive an incomplete referral:

- Referrals **missing sections or incomplete responses** insufficient to score a CASII will be returned.
- Referrals **missing Required Supplemental Documentation** will be closed after ten (10) business days.
    - After thirty (30) days a new and complete referral must be submitted.
- **Required Supplemental Documentation** Includes (where applicable):
    - ☐ If Private Insurance is indicated: Summary of Benefits and Coverage, including mental health and/or substance abuse coverage.
    - ☐ If Guardianship is indicated: Court order identifying guardianship rights.
    - ☐ If Developmental Delay is indicated: Documentation such as a psychoeducational evaluation, neurological assessment, or other evaluation indicating functioning, ability, and cognitive testing.
    - ☐ If Substance Use is the primary concern: Include a Substance Use assessment.

Next Steps:

- You will receive a confirmation call or email from Intake to confirm receipt of this referral. If you do not get a notification within 1 business day of sending the referral, please call us at 1-800-722-7710.

Intake Services

HIGHER LEVEL OF CARE REFERRAL – PROFESSIONAL

DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH & THEIR FAMILIES
DIVISION OF PREVENTION & BEHAVIORAL HEALTH SERVICES
Terry Center Pod 3, 10 Central Ave., New Castle, DE 19720 1-800-722-7710

Please fill out this form as completely as possible and call if you need assistance.

Fax this form to (302) 622-4475 or mail it to the address above or email to: DSCYF_Intake_General@state.de.us

CHILD/YOUTH INFORMATION

Date: _____ Child's Name: _____

DOB: _____ Gender: ☐ M ☐ F Race: _____ Ethnicity: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Family's preferred language: _____

School: _____ Grade: _____ Education Type: ☐ Regular ☐ Special

PARENT/GUARDIAN INFORMATION

Name: _____

Relationship to Child**: _____

Address: _____

City: _____ State: _____ Zip: _____

Best Phone Number: _____ Other Phone: _____

Email: _____

** If you are not the parent, please include a copy of the guardianship document(s) and/or court order(s) – failure to do so will result in delay or possible closure of the case.

INSURANCE INFORMATION

Active Medicaid: (Highmark Health Options, United Health Care)?

☐ Y ☐ N Member ID Number: _____

Private Insurance**: (Aetna, BCBS, etc.):

☐ Y ☐ N If yes, name of company: _____

Member ID Number: _____

** Please include a summary of mental health/substance abuse benefits available through your child's private insurance provider – failure to do so will result in delay or possible closure of the case.

TREATMENT INFORMATION

Is the child currently in outpatient treatment? ☐ Mental Health ☐ Substance Abuse ☐ None

- Sessions within last 30 days: Attended: _____ Scheduled: _____

MENTAL HEALTH AND/OR SUBSTANCE ABUSE TREATMENT HISTORY

Provider	Treatment Type (Outpatient/Inpatient/Psychiatry/Etc.)	Begin Date	End Date	Helpful?

CURRENT MEDICATION

Provider	Medication Name	Dose

***** If the child is being referred for substance abuse treatment, please seek an outpatient substance abuse assessment prior to completing this referral.***

REFERRAL AGENT

Completed by: _____ Organization/Agency: _____

Relationship to Child: _____ Position: _____

Email: _____ Phone: _____

Signature: _____

AUTHORIZATION SIGNATURE(S) -- REQUIRED

I give permission for the information in this referral to be given to DPBHS. I give permission for DPBHS to:

1. Contact people or agencies listed in this referral to obtain further information as needed
2. Share this information with the Medicaid office if they believe that my child may be eligible for disabled child coverage
3. Share this information with authorized service providers if my child is eligible for DPBHS services.

** Required for clients 14 or older seeking substance use treatment

Parent/Guardian Signature: _____ **Date:** _____

Youth Signature if 14 years or older:** _____ **Date:** _____

DPBHS Intake will call or email you to confirm receipt within 1 business day of receiving the referral. If you do not hear from us, please contact us at 1-800-722-7710 or verify the information was sent to the fax number/address on the first page of the referral.

Please explain why the youth cannot be safely and effectively treated in an outpatient setting:

RISK OF HARM

In the past 30 days, has the child had…	Current	Past	Never	*In the past 30 days, has the child had…*	Current	Past	Never
Suicidal Ideation	☐	☐	☐	Physical Aggression (person)	☐	☐	☐
Suicidal Plan	☐	☐	☐	Physical Aggression (objects)	☐	☐	☐
Suicide Attempt	☐	☐	☐	Homicidal Threat	☐	☐	☐
Self-Injury	☐	☐	☐	Homicidal Attempt	☐	☐	☐
Inappropriate Sexual Behaviors	☐	☐	☐	Firesetting	☐	☐	☐
Substance Use	☐	☐	☐	Cruelty to Animals	☐	☐	☐

If any of the above are checked please explain (include triggers and frequency/intensity/duration):

FUNCTIONAL STATUS

Identify how the youth is functioning in his/her family, the school setting, and in the community:

List youth's mental health diagnoses:

CO-OCCURRING CONDITIONS

Developmental* YES ☐ NO ☐

Substance Use** YES ☐ NO ☐

Medical YES ☐ NO ☐

* If yes, include a psychoeducational, neurological, or other evaluation indicating functioning, ability, and cognitive testing.

**If substance use is the primary condition please attach substance use assessment.

If any are checked yes please list diagnoses and explain the reason mental health is the primary condition (below):

Describe the impact of the **co-occurring condition** on the primary mental health condition:

RECOVERY ENVIRONMENT *(to include family, friends, natural supports, school, medical services, juvenile justice, child welfare, and community resources)*

Describe the environmental **stress** for this youth:

Describe the environmental **supports** for this youth:

RESILIENCY AND/OR RESPONSE TO SERVICES

Describe how the youth has responded to treatment and support services:

List the strengths, interests, and protective factors that the youth and family possess:

INVOLVEMENT IN SERVICES

List past services and describe the youth's ability to engage in these services (please include examples):

Describe the parent/caregivers ability to engage in past services (please include examples):

CONSENT FOR RELEASE OF CONFIDENTIAL MENTAL HEALTH INFORMATION DIVISION OF PREVENTION & BEHAVIORAL HEALTH SERVICES

Client Name:_____DOB:_____

I, (Parent/Guardian/Custodian/DFS) _____hereby authorize the Division of Prevention and Behavioral Health Services (DPBHS) to Release Verbal/Written Information to and to receive verbal and written information from:

Agency name or school:_____
Name of contact person at agency/school (if known):

Verbal and written information to be released by DPBHS: (Check all items that apply.)

- ☐ Admission / Discharge Summaries (DPBHS services for past 2 years)
- ☐ Service Admission Form (includes Demographics, CSM Service Plan, DPBHS Treatment History, Medication History, Risk Factors)
- ☐ DPBHS Psychosocial Evaluation ☐ DPBHS Psychological Evaluation ☐ DPBHS Psychiatric Evaluation
- ☐ Educational Records ☐ Treatment Progress/Summary
- ☐ Most recent physical exam (not to include pregnancy, STD, HIV information)
- ☐ Other: _____

The purpose of this information disclosure by DPBHS is to: (Check all items that apply.)

- ☐ Make a referral/provide treatment by the clinical treatment organization or person listed above
- ☐ Assist in the completion of PBHS Evaluation(s)
- ☐ Provide clinical information to organization or person named above

Verbal and written information to be released to DPBHS: (Check all items that apply.)

- ☐ Initial Evaluation ☐ Comprehensive Treatment Plan ☐ Discharge Summary
- ☐ Treatment Progress Summary ☐ Physical Examination ☐ Speech and Language Evaluation
- ☐ Neurological Evaluation ☐ Medication History ☐ Psychiatric Evaluation
- ☐ Most recent educational records including educational testing and school psychological, IEP/IPRD documents, school attendance and behavioral/disciplinary records
- ☐ Other _____

The purpose of this information disclosure by the agency/school named above is to: (Check all items that apply.)

- ☐ Enable PBHS to Plan, Monitor, Authorize Payment, Coordinate Care with Treatment Provider
- ☐ Enable PBHS to use the educational material in planning treatment
- ☐ Enable PBHS to collaborate with the school in planning and providing services
- ☐ Assist in the completion of PBHS Evaluation(s)

I understand that this form can not be used to release information about drug and alcohol treatment, pregnancy, HIV status, and sexually transmitted diseases.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present it to the Director of Quality Improvement in the Division of Prevention of Behavioral Health Services. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this release in order to be assured treatment. I understand that I may inspect or copy the information used or disclosed as provided in 45 C.F.R. 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and that the information may not be protected by federal confidentiality rules. If I have any questions about the disclosure of my health information, I can contact the Director of Quality Improvement, Division of Prevention and Behavioral Health Services.

This Release of Information demonstrates compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 C.F.R. pts. 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Once the requested Personal Health Information (PHI) is disclosed, the recipient may re-disclose it, therefore the privacy regulations may no longer protect it.

This authorization is valid for one year from the signature date unless revoked.

_____ _____
Parent, Guardian, Custodian, DFS Signature (Circle one) Print Name/Date

_____ _____
DSCYF Representative Signature Print Name/Date

DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH AND THEIR FAMILIES
Delaware Youth and Family Center
1825 Faulkland Road, Wilmington, DE 19805

CONSENT FOR THE RELEASE OF CONFIDENTIAL ALCOHOL OR DRUG TREATMENT INFORMATION

I, _____, authorize
(Print name of youth)

Please check appropriate box:

- ☐ Division of Family Services (DFS)
- ☐ Division of Youth Rehabilitation (YRS)
- ☐ Parent / Guardian
- ☐ Family Court
- ☐ Superior Court
- ☐ Department of Education (DOE)
- ☐ Multi Disciplinary Team (MDT)
- ☐ Deputy Attorney General's Office (DAG)
- ☐ Public Defender (PD) / Private Attorney (PA)
- ☐ Other (Please specify): _____

☐ To disclose ☐ To receive from the Division of Prevention and Behavioral Health Services the following information:

All information pertinent to substance abuse, including verbal communication, treatment progress and assessment, drug screen reports, and discharge summary.

The purpose of the disclosure authorized herein is to: Assist in completion of Prevention and Behavioral Health Services evaluation(s), treatment recommendations, and / or placement.

I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent, unless otherwise provided for in the regulations. I have the right to receive a copy of this form after completing it. I also understand that I may revoke this consent 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 as follows:

THIS AUTHORIZATION WILL EXPIRE TWELVE (12) MONTHS FROM DATE OF SIGNATURE

_____	_____	_____
Signature of Youth (mandatory for 14 years and older)	Print Name of Youth	Date
_____	_____	_____
Signature of Parent or Guardian (mandatory if client under 14 years old)	Print Name of Parent or Guardian	Date

PROHIBITION ON REDISCLOSURE OF INFORMATION CONCERNING CLIENT IN ALCOHOL OR DRUG ABUSE TREATMENT

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with consent of such a client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ **Age:** ____ **Sex:** ☐ **Male** ☐ **Female** **Date:**_____

Relationship with the child: _____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child …						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			