

CASSP of Westmoreland County

Child & Adolescent Service System Program



CASSP MEETING REFERRAL FORM

Date: _____

REFERRAL SOURCE	
Last Name: _____	First Name: _____
School District/Agency: _____	Position: _____
Phone #: _____	Email: _____
Reason for referral: _____	

FAMILY INFORMATION	
CHILD	
Last Name: _____	First Name: _____
Address: _____	City: _____ State: PA Zip Code: _____
School District: _____	Age: _____ Grade: _____
MOTHER / GUARDIAN	
Last Name: _____	First Name: _____
Address: _____	City: _____ State: PA Zip Code: _____
FATHER / GUARDIAN	
Last Name: _____	First Name: _____
Address: _____	City: _____ State: PA Zip Code: _____

Complete the following information in preparation of the CASSP meeting:

What is the anticipated goal or outcome of the CASSP meeting?

What domain of functioning is currently impacted?
<input type="checkbox"/> Academic <input type="checkbox"/> Family / Home <input type="checkbox"/> Social / Community

Is there a recent or current history of:	<input type="checkbox"/> Change in residence <input type="checkbox"/> Child Neglect <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Emotional Abuse	<input type="checkbox"/> Physical Abuse <input type="checkbox"/> Sexual Abuse/Molestation <input type="checkbox"/> Trauma <input type="checkbox"/> Other _____	Legal System Involvement:	<input type="checkbox"/> Child Welfare <input type="checkbox"/> Custody Courts <input type="checkbox"/> Criminal Justice System <input type="checkbox"/> Juvenile Probation Svcs
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Does the child have IEP? Yes No Date of last IEP: _____
 Does the child have a 504 plan? Yes No Date of last Plan: _____

Child's Strengths

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Child's Area(s) of Concern or Need

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Current agency/agencies involved with the child/family

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Service Utilization / Current or Prior Involvement

				Date Svc Began	Date Svc Ended
Intensive Behavioral Health Services (IBHS) <small>(formerly known as BHRS)</small>	<input type="checkbox"/>	Current	<input type="checkbox"/>	Prior	_____
Casemanagement / Support Coordination	<input type="checkbox"/>	Current	<input type="checkbox"/>	Prior	_____
Community Residential Rehabilitation (CRR)	<input type="checkbox"/>	Current	<input type="checkbox"/>	Prior	_____
Drug & Alcohol Outpatient	<input type="checkbox"/>	Current	<input type="checkbox"/>	Prior	_____
Family Based MH Services	<input type="checkbox"/>	Current	<input type="checkbox"/>	Prior	_____
Inpatient Hospitalization	<input type="checkbox"/>	Current	<input type="checkbox"/>	Prior	_____
Multi-Systemic Therapy (MST)	<input type="checkbox"/>	Current	<input type="checkbox"/>	Prior	_____
Mental Health Outpatient (Clinic or School-based)	<input type="checkbox"/>	Current	<input type="checkbox"/>	Prior	_____
Partial Hospitalization	<input type="checkbox"/>	Current	<input type="checkbox"/>	Prior	_____
Residential Treatment	<input type="checkbox"/>	Current	<input type="checkbox"/>	Prior	_____
Student Assistance Program (SAP)	<input type="checkbox"/>	Current	<input type="checkbox"/>	Prior	_____

Please identify agencies/person(s) you feel should participate in CASSP meeting.

Contact Name	Address	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Additional Comments

Are you willing to host the CASSP meeting at your school or agency? Yes (Please list address below) No

FOR OFFICE USE ONLY – CASSP MEETING INFORMATION

- Tier One
- Tier Two
- Tier Three

Date: _____
Time: _____
Location: _____

Referral Source Signatures

I helped to complete the CASSP Meeting Referral Form and my signature(s) below acknowledges that the information stated above is accurate to the best of my ability. My signature also acknowledges that the parent(s), guardian(s), and/or the child(ren) assisted in the completion of this form.

Signature of Referral Source

Date

Signature of Mother/Guardian

Date

Signature of Father/Guardian

Date

Signature of the Child (if over 14 years of age)

Date

Authorization to Release Information

We, the undersigned, hereby give our consent for the exchange and discussion of the confidential information concerning my/our family at the CASSP Meeting, which includes core team members and other involved parties. I/We also give consent to the members who represent the agencies to facilitate a discussion and sharing of information for the purpose of the CASSP Meeting.

Youth

Date

Mother/Guardian

Date

Father/Guardian

Date

Witness

Date

Please send completed form to

Renee Dadey
Westmoreland County BHDS
40 N. Pennsylvania Avenue
Suite 110
Greensburg, PA 15601

Or

dadeyr@westmoreland.swsix.com

If you have any questions, please call (724) 830-3617.