

# ADDENDUM

## A



Cuyahoga County Family and Children First Council

REFERRAL FORM

Caller's Name \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_

Caller's Relationship to Child \_\_\_\_\_

Child's Name: \_\_\_\_\_ Custody Status: \_\_\_\_\_

Age : \_\_\_\_\_ Sex: \_\_\_\_\_

Language, if other than English: \_\_\_\_\_

School/District \_\_\_\_\_ School contact/# \_\_\_\_\_

Education: Regular \_\_\_\_\_ Special \_\_\_\_\_ Grade \_\_\_\_\_ Designation (if applicable) \_\_\_\_\_

Agencies Involved with youth, or family:

\_\_\_\_\_ ADAMHS \_\_\_\_\_ CCDCFS \_\_\_\_\_ CSEA \_\_\_\_\_ DSAS \_\_\_\_\_ EFS \_\_\_\_\_ HMG

\_\_\_\_\_ JA \_\_\_\_\_ JC \_\_\_\_\_ BDD \_\_\_\_\_ PEP \_\_\_\_\_ Catholic Charities

Other Agencies \_\_\_\_\_

Briefly describe the nature of your concerns/needs and current family situation:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Issues affecting the family:

\_\_\_\_\_ Substance Abuse \_\_\_\_\_ Education \_\_\_\_\_ Custody/Visitation

\_\_\_\_\_ Mental Health \_\_\_\_\_ Physical Health \_\_\_\_\_ System Barriers

\_\_\_\_\_ Developmental Disabilities \_\_\_\_\_ Child behavioral concerns \_\_\_\_\_ Financial

Other, Please list \_\_\_\_\_

Office use only

Date Received \_\_\_\_\_ Date Contacted Caller \_\_\_\_\_

Outcome of Call \_\_\_\_\_ Date Completed \_\_\_\_\_

# **CARE COORDINATION SCREENING TOOL**

This tool will be used when children are at risk of disrupting a foster care setting, birth parent, and/or a relative placement related to emotional/behavioral challenges.

**IF THE ANSWER TO #1, #2, #3, #4 OR #5 IS YES, THEN THE CHILD DOESN'T QUALIFY FOR THE CARE COORDINATION PROJECT.**

1. \_\_\_\_\_ Child is placed outside of Cuyahoga
2. \_\_\_\_\_ Child is currently begin served by PEP Tapestry/PEP Connections
3. \_\_\_\_\_ There is not a Care Coordination slot available in the child's current Geographic area
4. \_\_\_\_\_ Placed in a network foster home.
5. \_\_\_\_\_ Are there any immediate safety concerns

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**IF THE ANSWER TO #1, #2, #3, #4 OR #5 WERE NO, CONTINUE TO COMPLETE THE REST OF THE FORM.**

6. \_\_\_\_\_ Has there been SOC involvement in the past?
7. \_\_\_\_\_ Case active as a FIN based on the behavioral/emotional needs of the child (ren)
8. \_\_\_\_\_ The child at risk of disrupting due to emotional/behavioral needs that may require a higher level of care.
9. \_\_\_\_\_ Child has complex needs and is multi-system involved: i e.-Juvenile Court, Drug and Alcohol, Mental Health (Other then PEP or Tapestry).
10. \_\_\_\_\_ Does the child have a mental health diagnoses: \_\_\_\_\_
11. \_\_\_\_\_ Child and family are willing to work through the presenting crisis. If yes characteristics or willingness of legal custodian: \_\_\_\_\_
12. \_\_\_\_\_ Type of referral: Birth Parents/Adopted Parents/Kinship/ Foster care/Group Home/Residential/Independent Living \_\_\_\_\_
13. \_\_\_\_\_ Have there been interventions used to stabilize the placement?  
Yes, What? \_\_\_\_\_  
\_\_\_\_\_
14. \_\_\_\_\_ Services are needed? \_\_\_\_\_
15. \_\_\_\_\_ Staffing date/type \_\_\_\_\_

**Child's Name:** \_\_\_\_\_ **Person #** \_\_\_\_\_

**Medicaid #** \_\_\_\_\_

**Social**

**Worker:** \_\_\_\_\_ **Supervisor:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Today's Date:**     /     /

Please forward to Jimmy Mazzola, 881-5338 ( Rm.124-East)  
Yulanda Wiley, Rm. 110e, 310-2822, ywiley@cuayhogacounty.us

## JUVENILE COURT SYSTEMS OF CARE REFERRAL FORM

If the answer to any of the following question is “yes”, the youth is not eligible for Systems of Care Services:

- |                          |                          |   |
|--------------------------|--------------------------|---|
| No                       | Yes                      |   |
| <input type="checkbox"/> | <input type="checkbox"/> | Child resides outside of Cuyahoga County.                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Youth is placed in the custody of CFS.                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Youth is currently receiving wrap around services from PEP Connections. |
| <input type="checkbox"/> | <input type="checkbox"/> | Youth is 18 years of age.   |
| <input type="checkbox"/> | <input type="checkbox"/> | Has there been SOC services in the past**                               |

(Referral packet should include: one copy of the record and the ORIGINAL release, signed by the Guardian and witnessed by the Referent.)

Date:	Referring	Phone #:
Case #:	Name:	DOB:
Address:		Phone #:
Parent/Guardian:		
Charge:	Jurist:	
Next Court date:	Client's location:	
Comments/special instructions:		
Youth is Medicaid eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No        Medicaid #:		

Mail referrals to SOC Liaison:

Yulanda Wiley  
1400 W. 25<sup>th</sup> Street, 4<sup>th</sup> Floor  
Cleveland, OH 44113  
Office: 443-6138; Cell: 310-2822  
[ywiley@cuyahogacounty.us](mailto:ywiley@cuyahogacounty.us).

\*Court Liaison is Barb Kohuth: (office) 216-698-2708; (cell) 216-310-4720;  
[bkohuth@cuyahogacounty.us](mailto:bkohuth@cuyahogacounty.us).

\* Care Managers – please notify the referring Probation Officer when the case is assigned to you.

\*\* Please contact SOC Enrollment Specialist for more discussion.



### PEP Referral System

Connections Home      Gonzales, Mondie - PEP - Referral/Demographic Information

Latest News

**[Demographic]**   [Community]   [Mental Health]   [Referral]

Admission Criteria

Staff

\*First Name:  \*Last Name:  M.I.

On Line Referral

SSN:  \* DOB:

Contact Us

Phone:  \*Sex:  Male  Female

Alt. Contact:  Phone:

\*Race Group:  --Select--

Ethnicity:  --Select--

**Current Living Address (All information below for Parent/Guardian/Caretaker)**

Name:

\*Address:

Address Line 2:

\*City:  \*State:  \*Zip:

**Legal Address, if different than Current Address**

Name of Parent/  
Legal Guardian:

Address:

Address Line 2:

City:  State:  Zip:

**Custody Information**

\*Type Of Custody:  No Court-ordered Custody  \*Who has Custody:  --Select--

If other, please specify:

**Save**   **Next**

Save button saves current page. Next button saves and moves to next page.

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### PEP Referral System

**Connections Home**

Gonzales, Mondie - PEP - Referral/Community Information for 'fare, fake'

**Latest News**

[Demographic] **[Community]** [Mental Health] [Referral]

**Admission Criteria**

**Staff**

**\*Is this Child currently enrolled in school:**  Yes  No

**On Line Referral**

**Contact Us**

**School Enrolled:**

**Contact:**  **Phone:**

**Last Grade Completed:** --Select--

**Educational Placement:**

- Regular Education
- Emotional Disturbance
- Multiple Disabilities
- Hearing Impairment including deafness
- Visual Impairment including Blindness
- Other Specify:
- Specific Learning Disability
- Cognitive Disability (mental retardation)
- Autism
- Orthopedic Impairment/Handicapped
- Preschool Child with a Disability

**Specify if Other or SLD:**

**Is this child currently involved in any system-of-care wrap around programs?**

Yes  No  Unknown

**If Yes, Agency:**

**Contact:**  **Phone:**

**\*Current System Involvement: Please check 'Yes' for each agency that is applicable, and 'No' for each agency that is not applicable.**

Yes	No	Unknown	System	Contact	Phone
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	CCDCFS	Worker's Name: <input type="text"/>	<input type="text"/>
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Ohio Dept. Youth Srv.	Worker's Name: <input type="text"/>	<input type="text"/>
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Community Agency	Agency Name: <input type="text"/> Contact: <input type="text"/>	<input type="text"/>
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Juvenile Court	P O 's Name: <input type="text"/>	<input type="text"/>
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Juvenile Court Diversion	Contact's Name: <input type="text"/>	<input type="text"/>
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Board of MR/DD	Worker's Name: <input type="text"/>	<input type="text"/>
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Private Hospital/Healthcare Provider	Contact: <input type="text"/>	<input type="text"/>
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Private MH Professional	Name: <input type="text"/>	<input type="text"/>
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Mobile Crisis Team	Contact: <input type="text"/>	<input type="text"/>
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Alcohol and Drug Addiction Services	Contact: <input type="text"/>	<input type="text"/>
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Bureau Of Voc Rehab	Contact: <input type="text"/>	<input type="text"/>
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Guardian ad Litem(GAL)	Name: <input type="text"/>	<input type="text"/>
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Other	Other: <input type="text"/>	<input type="text"/>

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If child has ever been placed out of his/her home, enter the number of placements in each category below. If child has never been placed out of his/her home, leave categories below blank:

Emergency Shelter:	<input type="text"/>
Foster Home:	<input type="text"/>
Adoptive Home:	<input type="text"/>
Detention Home:	<input type="text"/>
Residential Treatment:	<input type="text"/>
Psychiatric Hospitalization:	<input type="text"/>
Group Home:	<input type="text"/>
Correctional Facility:	<input type="text"/>
Other:	<input type="text"/>

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**PEP Referral System**

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**Connections Home** Gonzales, Mondie - PEP - Referral/Mental Health Information 'fare, fake'

**Latest News**

[Demographic] [Community] **[Mental Health]** [Referral]

**Admission Criteria**

**Staff**

**Presenting Problems: Please check All that apply\***

**On Line Referral**

**Contact Us**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Academic Problems                  | <input type="checkbox"/> Eating Disorder/Problems          | <input type="checkbox"/> Runaway                       |
| <input type="checkbox"/> Aggressive Behavior                | <input type="checkbox"/> Fire Setting                      | <input type="checkbox"/> School Dropout                |
| <input type="checkbox"/> Alcohol/Chemical Abuse             | <input type="checkbox"/> Gang Involvement                  | <input type="checkbox"/> Self Care/Hygiene Failure     |
| <input type="checkbox"/> Anxious                            | <input type="checkbox"/> Hallucinations                    | <input type="checkbox"/> Self-Injurious                |
| <input type="checkbox"/> Assaultive                         | <input type="checkbox"/> HIV or AIDS                       | <input type="checkbox"/> Separation Anxiety            |
| <input type="checkbox"/> Attachment Problems                | <input type="checkbox"/> Hyperactive Behavior              | <input type="checkbox"/> Sex Offender                  |
| <input type="checkbox"/> Attention-Seeking Behaviors        | <input type="checkbox"/> Inattention - Poor Concentration  | <input type="checkbox"/> Sexually Abused               |
| <input type="checkbox"/> Autistic Spectrum                  | <input type="checkbox"/> Enuretic/Encopretic               | <input type="checkbox"/> Sexually Inappropriate        |
| <input type="checkbox"/> Blind/Visually Impaired            | <input type="checkbox"/> Learning Problem                  | <input type="checkbox"/> Sibling Conflict              |
| <input type="checkbox"/> Child of Alcohol/Other Drug Abuser | <input type="checkbox"/> Lying                             | <input type="checkbox"/> Sleep Problems                |
| <input type="checkbox"/> Compulsive Behavior                | <input type="checkbox"/> Memory Impairment                 | <input type="checkbox"/> Social Withdrawal (Isolation) |
| <input type="checkbox"/> Cruelty to Animals                 | <input type="checkbox"/> Mental Illness/Mental Retardation | <input type="checkbox"/> Social Skills Deficit         |
| <input type="checkbox"/> Cult Involvement                   | <input type="checkbox"/> Mood Swings                       | <input type="checkbox"/> Speech problems               |
| <input type="checkbox"/> Deaf/Hearing Impaired              | <input type="checkbox"/> Neglected                         | <input type="checkbox"/> Stealing                      |
| <input type="checkbox"/> Delusions                          | <input type="checkbox"/> Nightmares                        | <input type="checkbox"/> Suicidal Thoughts             |
| <input type="checkbox"/> Depressed Mood                     | <input type="checkbox"/> Non-Compliance/Oppositional       | <input type="checkbox"/> Suicidal Attempts             |
| <input type="checkbox"/> Destructive to Property            | <input type="checkbox"/> Paranoid/Suspiciousness           | <input type="checkbox"/> Suicidal Gestures             |
| <input type="checkbox"/> Developmental Delays               | <input type="checkbox"/> Physically Abused                 | <input type="checkbox"/> Temper Tantrums               |
| <input type="checkbox"/> Developmentally Disabled           | <input type="checkbox"/> Physically Challenged             | <input type="checkbox"/> Tics                          |
| <input type="checkbox"/> Disruptive in School               | <input type="checkbox"/> Poor Peer Relations               | <input type="checkbox"/> Truancy                       |
| <input type="checkbox"/> Domestic Violence Perpetrator      | <input type="checkbox"/> Poor Self-Esteem                  | <input type="checkbox"/> Unrealistic Fears             |
| <input type="checkbox"/> Domestic Violence Victim           | <input type="checkbox"/> Probation/Parole                  | <input type="checkbox"/> Vandalism                     |
| <input type="checkbox"/> Domestic Violence Witness          | <input type="checkbox"/> Risk Taking                       |  |

**Other (Specify):**

**Mental Health Service History\***

Area	Never	Currently	During Last 12 Months	More Than 12 Months Ago	Unknown
<b>Private Mental Health Professional:</b>	<input type="checkbox"/>				
<b>Psychiatric Hospital:</b>	<input type="checkbox"/>				
<b>Positive Education Program:</b>	<input type="checkbox"/>				
<b>Other Community Agency:</b>	<input type="checkbox"/>				
<b>Residential Treatment Facility:</b>	<input type="checkbox"/>				
<b>Other:</b> <input type="text"/>	<input type="checkbox"/>				

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\*Is this child prescribed psychotropic drugs?:  Yes  No  Unknown

List meds, if known:

If child has been assigned a mental health diagnosis, please list Current Diagnoses:

DSM - IV: Code:  Disorder:

Code:  Disorder:

Code:  Disorder:

Save button saves current page Next button saves and moves to next page. Prev button saves and moves to previous page.

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### PEP Referral System

**Connections Home** Gonzales, Mondie - PEP - Referral/Referral Information 'fare, fake'

**Latest News**

[Demographic] [Community] [Mental Health] **[Referral]**

**Admission Criteria**

**Staff**

**\*How did you learn of this program?** --Select--

**On Line Referral**

**If Other, please specify:**

**Contact Us**

**\*Do You have the following information for this child?**

- Yes  No Diagnostic/Mental Health Assessment?
- Yes  No Psychological or Psychiatric Evaluations or Reports?
- Yes  No Hospital Psychiatric Admission or Discharge Summaries/Reports?
- Yes  No Therapy Summaries/Notes?
- Yes  No Special Education Evaluations?

**\*What is causing you to make this referral at this time?**

**Any Final Comments?**

Save button saves current page. Prev button saves and moves to previous page. Submit button saves and submits data.

[Log off] [Back To List]



Child's Name: \_\_\_\_\_ DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**PLEASE COMPLETE ALL AREAS THAT MAY APPLY**

**Early Intervention / Part C Referral**

Child has a diagnosis/es. Please list all diagnoses: \_\_\_\_\_

Child born with Very Low Birth Weight (under 3 lbs 5 oz. or 1500 grams) \_\_\_\_\_ (weight)

Child born at Low Birth Weight (under 5 lbs 8 oz. or 2500 grams) with complications \_\_\_\_\_ (weight) (Describe below)

Child has blood lead level of \_\_\_\_\_  $\geq$ 15 mcg/dl

Child has a suspected delay in one or more areas of development:

- Adaptive     Communication     Social and Emotional     Cognitive     Physical

Please describe medical or health complications or any concerns: \_\_\_\_\_

**Help Me Grow Home Visiting**

Families are eligible for parenting education through Home Visiting if they meet any of the following categories.

**Please check ALL factors in each category that may apply:**

<p><b>First Time Parents:</b> New parents are eligible for Help Me Grow Home Visits if they meet <b>ALL</b> of the following factors:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> First time mother or first time father with custody;</li> <li><input type="checkbox"/> Expectant mother or the child is under 6 months of age; and</li> <li><input type="checkbox"/> Family income is less than or equal to 200% of federal poverty level</li> </ul>	<p><b>High Risk Families:</b> High risk families are eligible for Help Me Grow Home Visits in Cuyahoga County if they meet <b>two (2)</b> of the following risk factors: (Please check)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Adolescent parent up to age 20</li> <li><input type="checkbox"/> Single Parent</li> <li><input type="checkbox"/> Parent with history of abuse or neglect, domestic violence</li> <li><input type="checkbox"/> Lack of stable residence, homelessness or dangerous living conditions</li> <li><input type="checkbox"/> Parent with chronic or acute mental illness or developmental disability</li> <li><input type="checkbox"/> Maternal prenatal substance abuse</li> <li><input type="checkbox"/> Parent with drug or alcohol dependence</li> </ul>	<p><b>Other Eligible Families:</b> Other families are eligible if they meet <b>any</b> of the following factors: (Please check)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Parent is active military personnel</li> <li><input type="checkbox"/> Any child referred by DCFS with substantiated abuse/neglect (CAPTA) is automatically eligible</li> <li><input type="checkbox"/> Exceptions may be made on an individual basis for children who have extremely high risks, but do not meet eligibility requirements.</li> </ul>
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Other Comments: \_\_\_\_\_

Exceptions may be made on an individual basis. Please describe: \_\_\_\_\_

# ADDENDUM

## B



COMMISSIONERS  
Jimmy Dimora  
Timothy F. Hagan  
Peter Lawson Jones

## INSTRUCTIONS FOR AUTHORIZATION FOR RELEASE OF INFORMATION

We tried to make the form easy to read. If you don't understand something, please ask!

- We believe that we can provide better services for your child if systems and providers can share information.
- Several laws prevent us from sharing information unless you approve.
- The form allows systems and providers to share information only for the reasons stated.
- Kent State University (KSU) evaluates the quality and cost-effectiveness of Tapestry services. Your child/family will not be identified in any reports or research published by KSU.
- You may cancel or revoke the authorization at any time. You may limit the authorization's time frame at any time.
- We will give you a copy of the Authorization.

### Authorized Providers and Systems

- You do not have to authorize the release of information from all systems and providers. But, if you don't, this may result in a delay of services to your child and family. (This will not affect public benefits and services for which you or your child are eligible.)
- Most public systems are listed on the form. Please identify your child's school and district and other public systems that might have helpful information.
- A Tapestry private provider is assigned to coordinate your child's care. If your child has records at other providers, please check those or identify them.
- Parent support partner services are available for some families. Tapestry's parent support provider (Community Care Network) is listed on the form. If you agree to a parent support partner, CCN will need information.
- Tapestry works with Neighborhood Collaboratives, providing care coordination in your child's neighborhood. Please identify your neighborhood collaborative.

### Information to Be Exchanged:

- Listed on the form are categories of information that would be helpful in providing services.
- Special laws apply to some categories (e.g., education records, alcohol and drug records) as noted.
- Systems and providers will share information only with other authorized systems and providers.
- We ask you to authorize the financial information only to verify your and your child's eligibility for public assistance. (e.g., Medicaid)

### Authorization

- Sometimes systems and providers are asked to share information received from one authorized system or provider with another. This is called redisclosure.
- Please initial the line approving the noted time frame **OR** limit the time frame by inserting a date.
- A parent or legal guardian must sign and date the form. Any child 12 or over must sign and date the form.
- A witness will also sign and date the form.

### Cancellation

- If you decide to cancel this release, you will need to sign and date the form and submit it to your Care Coordinator.



COMMISSIONERS  
 Jimmy Dimora  
 Timothy F. Hagan  
 Peter Lawson Jones

**AUTHORIZATION FOR RELEASE OF INFORMATION**

**Purpose of Form and Uses of Information:** This authorization allows the noted systems and providers to share information about the child named below. Information will be used to: (1) develop the child's treatment planning, (including wraparound services); (2) coordinate and pay for services; and (3) evaluate the quality and cost-effectiveness of services.

Child's Name	Soc. Sec. No.	Date of Birth (mm/dd/yyyy)
Address:		Tel. No. ( )
City	State/Zip	

**Authorized Systems and Providers:** The listed public systems and private providers work together as Cuyahoga Tapestry System of Care (Tapestry). **Kent State University**, our research and evaluation partner, helps judge the quality and cost-effectiveness of our efforts. **Community Care Network** provides parent support partners to help families navigate the systems.

- Check (✓) the **EXC** box to consent to 2-way sharing OR
- Write **(DIS)** in the EXC box if **only** disclosing information or **(REC)** if **only** receiving information.
- Identify the child's **school/district** and any other systems or private providers whose information might help us provide better services for the child.

EXC	PUBLIC SYSTEMS
✓	Cuyahoga Tapestry System of Care
	Cuyahoga County Juvenile Court
	Cuyahoga County Department of Children and Family Services
	Cuyahoga County Community Mental Health Board
	Alcohol and Drug Addiction Services Board of Cuyahoga County
	Cuyahoga County Board of Mental Retardation and Developmental Disabilities
	Kent State University (for research and evaluation purposes)
	Cuyahoga County Dept. of Jobs and Family Services
	_____ School/School District
	Other (i.d.)
	Other (i.d.)

EXC	PRIVATE PROVIDERS
	Applewood Centers
	Beech Brook
	Bellefaire JCB
	Berea Children's Services
	Catholic Charities/Parmadale
	Cleveland Christian Home
	Community Care Network (for parent support partners)
	Positive Education Program (PEP)
	The Village Network
	Neighborhood Collaborative _____
	Other (i.d.)

**Information to Be Exchanged:** (Initial all that apply) - includes records from the previous 12 months, unless otherwise limited

- \_\_\_\_\_ Identifying Information: (Name, birth date, sex, race, address, telephone number)
- \_\_\_\_\_ Social Security Number, UCI number if any (for Medicaid purposes)
- \_\_\_\_\_ Education Records, per 34 CFR Part 99
- \_\_\_\_\_ Mental Health Records: Personal/social history, Psychological/Psychiatric Assessments, Evaluations, Treatment & Service History
- \_\_\_\_\_ Juvenile Court records
- \_\_\_\_\_ Medical Records – records of health care providers related to general health (Except HIV, AIDs and drug and alcohol treatment)
- \_\_\_\_\_ AIDS/HIV diagnoses, tests and other communicable diseases, as permitted by state and federal law
- \_\_\_\_\_ Alcohol and/or Drug Abuse Treatment records as permitted by state and federal law (42 CFR Part 2)

Financial information necessary to establish eligibility for public assistance.  
(This may include pay stubs, W-2 and tax return information, and other general financial information.)

### AUTHORIZATION

- I authorize the checked systems and providers to exchange/disclose/receive the initialed information about the child identified above for the reasons noted.
- I understand that signing or refusing to sign this consent will not affect public benefits or services for which the child or I are eligible, unless otherwise required by law.
- Expiration:** I understand that this authorization will expire six (6) months after the termination of the child's enrollment in Tapestry, **unless I limit the time frame or cancel this authorization in writing.** (The 6 month time frame after disenrollment allows for service follow-up, billing reconciliation and research clarification.) \_\_\_\_\_

Initials

Or I choose to limit the time frame to the following date: \_\_\_\_\_

- I understand that canceling this authorization does not apply to any information already shared in reliance on this authorization
- I understand that information used or disclosed may be subject to redisclosure and may no longer be protected under federal law.

Printed Name: Parent/Legal Guardian

Signature

Date

Printed Name: Child/Youth  
(if 12 years of age or over)

Signature

Date

Printed Name: Witness/Agency/System

Signature

Date

### TO ALL AGENCIES SENDING AND/OR RECEIVING INFORMATION DISCLOSED UNDER THIS AUTHORIZATION

- If the records released include information of any diagnosis or treatment of drug or alcohol abuse, the following statement applies:

#### PROHIBITION

#### ON REDISCLOSURE OF INFORMATION CONCERNING CLIENTS IN ALCOHOL OR DRUG ABUSE TREATMENT.

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 any 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.

- HIV RECORDS:** If the records released include information of an HIV-related diagnosis or test results, the following statement applies: This information has been disclosed to you from confidential records protected from disclosure by state law. You shall make no further disclosure of this information without the specific, written, and informed release of the individual to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for the purpose of the release of HIV test results or diagnoses.
- ALL RECORDS:** The information has been disclosed to you from records protected by federal and/or state confidentiality rules. Any further release is prohibited unless expressly permitted by the person to whom it pertains, by Juvenile Court/DYS in the case of youth records, or under applicable federal and/or state law.

### CANCELLATION

I, the parent/legal guardian named above, wish to cancel this authorization effective as of this date: \_\_\_\_\_

Signature of Parent/ Guardian: \_\_\_\_\_

Witness Initials: \_\_\_\_\_

## AUTHORIZATION & CONSENT FOR RELEASE OF INFORMATION

Client's Full Name	Date of Birth
Social Security Number	Individual Case Number (optional)

The following persons/programs/agencies have my permission to coordinate service planning and delivery for the above named person by disclosing specific information for the following specific purpose (s): \_\_\_\_\_

**Please identify all persons/programs/agencies that may disclose and/or receive information.**

<input type="checkbox"/> <b>Positive Education Program</b> _____ <input type="checkbox"/> <b>Help Me Grow</b> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
--	--

I authorize the release of the specific information for which I have circled and initialed below only if it is necessary to secure or coordinate needed services identified in my case plan by the persons/programs/agencies identified above:

Circle yes and initial

- yes \_\_\_\_\_ Identifying information: name, birth date, sex, race, address and telephone number
- yes \_\_\_\_\_ Social Security Number
- yes \_\_\_\_\_ General Medical: medical records (except for HIV, AIDS and drug and alcohol treatment records) disability, type of services being received and name of agency providing services to me or the individual named above.
- yes \_\_\_\_\_ Social History: social history, treatment/service history, psychological evaluations and other personal information regarding the individual named above or me.
- yes \_\_\_\_\_ School Information: grades, attendance records, Individualized Education Plan (IEP), Individualized Family Service Plan (IFSP), Individualized Service Plan (ISP), Multi-Factored Evaluation (MFE), (Children's) Ohio Eligibility Determination Instrument (COEDI/OEDI), transition plans and vocational assessments regarding me or the individual named above.
- yes \_\_\_\_\_ HIV and AIDS related diagnosis and treatment.
- yes \_\_\_\_\_ Current substance abuse treatment, recommendations and involvement specifically, \_\_\_\_\_
- yes \_\_\_\_\_ Financial Information necessary to establish eligibility for public assistance including but not limited to pay stubs, W2's and tax returns, and other financial information.
- yes \_\_\_\_\_ Other \_\_\_\_\_



COMMISSIONERS: Jimmy Dimora Peter Lawson Jones Tim McCormack

I understand that my alcohol and drug abuse patient records are protected under the Federal regulations governing confidentiality of those records, (42 CFR Part 2), cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand this Release expires 180 days from the date it is signed unless otherwise indicated by me. I also understand that I may cancel this Release at any time in writing with my signature, and the date it is signed, and delivering it to \_\_\_\_\_ Canceling it applies to that day forward and not to information already shared.

I understand that signing or refusing to sign this Release will not affect public benefits or services for which I am eligible, unless otherwise required by the regulations of the agency

I understand that the information disclosed pursuant to this authorization may be the subject of re-disclosure by the recipient without further protection

If not previously revoked, this consent expires on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness/Agency Representative

\_\_\_\_\_  
Date

*Violation of Federal law and regulations by a program is a crime Suspected violations may be reported to the United States Attorney in the district where the violation occurs*

**TO ALL AGENCIES SENDING AND/OR RECEIVING INFORMATION DISCLOSED AS A RESULT OF THIS SIGNED CONSENT:**

- 1 If the records released include information of any diagnosis or treatment of drug or alcohol abuse, the following statement applies:

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

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 any 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.

- 2 If the records released include information of an HIV-related diagnosis or test results, the following statement applies:

This information has been disclosed to you from confidential records protected from disclosure by state law. You shall make no further disclosure of this information without the specific, written and informed release of the individual to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for the purpose of the release of HIV test results or diagnoses.

- 3 The information has been disclosed to you from records protected by federal and/or state confidentiality rules. Any further release of it is prohibited unless the further disclosure is expressly permitted by the person to whom it pertains, Juvenile Court/DYS in the case of youth records, or applicable federal and/or state law.

Client's Name: \_\_\_\_\_



## AUTHORIZATION & CONSENT FOR RELEASE OF INFORMATION USER CHECKLIST

Client's Name: \_\_\_\_\_

- 1. Explain that the Release is **voluntary** not mandatory.
- 2. Explain the purpose of the Release: **to expedite services to the person who needs services from more than one agency.**
- 3. Explain that not signing it will not result in a refusal of services, but could result in a **delay of services**
- 4. **Review** all parts of the release with the client and explain the purpose of each part.
- 5. **Review the specific information** that the client authorized and initialed.
  - Make it clear to the client that he/she can authorize release of all data listed or only some, as he/she chooses.
  - Explain that the client can authorize release of only a portion of information in a category by crossing out information they did not desire shared.
- 6. Inform the person that they can **revoke** the Release at any time for any reason, by stating so in writing to the coordinating agency; show them a copy of the Release Revocation
- 7. Explain that the Release is **valid for up to 180 days**, unless it is revoked sooner. Ensure the client understands that when the Release expires agencies can no longer share information unless a new release is signed.
- 8. If the person whose records are to be released is a **minor**, ensure the parent or guardian understands the Release, completes it, and signs it; without this process and signature the Release is not valid.
- 9. Ensure you **review** with the client the information stated on the release regarding **HIV related diagnosis and substance abuse diagnosis and treatment**. NOW, if the person believes completing the Release will expedite services to them, ask them to complete it.
- 10. Note: **child abuse/neglect records** may only be released with the written permission of the County Public Children's Services Agency.
- 11. Encourage the client to know what is in his/her records before authorizing the release.

**Note:** This consent form may be used to share information with the following systems/providers: Alcohol and Drug Addiction Services Board and all ADASB contracted agencies, Board of Mental Retardation and Developmental Disabilities, Community Mental Health Board and all MH contracted agencies, Department of Children and Family Services, Juvenile Court/DYS, Help Me Grow, Cuyahoga Employment and Family Services, Ombudsman, Day Care/Headstart, Child Support, Department of Senior and Adult Services, Board of Health & Municipal Health Departments, Justice Affairs, all school districts located in Cuyahoga County, Hospitals, Medical Professionals (Pediatricians/Physicians, Dentists, Psychiatrist, Psychologist, Therapists, etc.), Community Providers (Public & Private) for the purpose of referral, respite (in-home and out-of-home) and/or placement

# ADDENDUM

## C



# ADDENDUM

## D

THE STRENGTHS, NEEDS, CULTURE & VISION DISCOVERY

Family Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Introduction:** (Describe who is in this child and family's ecology. Also describe why this child/family has been brought to your attention):

--

**Life Domains:** Describe this family's culture, values, strengths, and needs as they apply in each of the following domains:

**Domains**  
Family

--

Friends

--

THE STRENGTHS, NEEDS, CULTURE & VISION DISCOVERY

Domains

Leisure

Emotional

Safety

Spiritual/Faith

THE STRENGTHS, NEEDS, CULTURE & VISION DISCOVERY

Domains	
Medical	
Educational	
Vocational	
Financial	

THE STRENGTHS, NEEDS, CULTURE & VISION DISCOVERY

Domains

Legal

Other

List 2 or 3 Priority Needs:



Mother has worked at current job for 5 years and has been a steady, reliable employee

Mother has provided for herself and her family since she was 18

C.R. Mother has previously accessed community services for housing through Cleveland Housing Network.

██████████'s godmother remains active in his life, despite living out of state.

Family does have extended family in the area

██████████ likes math.

Mother tries to maintain good communication with school

#### Our Family History:

Strengths, Need, Culture, and Vision Discovery for ██████████ – June 2009

#### Introduction

██████████ is a nine year old African-American male who lives with his mother, his siblings, and mother's boyfriend on the southeast side of Cleveland. Mother has had many concerns about ██████████'s behaviors and has sought mental health services through Beechbrook. Mother felt that additional support was needed, and therapist did a referral to I'apestry. ██████████ and his mother were interviewed in developing this SNCD

#### Family

##### Strengths:

██████████'s immediate family includes: ██████████ (mother), ██████████ (sister, age 13), ██████████ (sister, age 10), ██████████ (brother, age 7), and ██████████ (sister, age 3). Mother describes ██████████ as so sweet and that she loves him. Mother is trying to teach the children to love each other and the importance of getting along because all they have is each other. Mother describes children as having some typical sibling conflict but that ██████████ takes it to extremes, becoming physically aggressive. Sometimes the children try to mother their younger siblings. Mother uses various forms of discipline with the children and often intervenes in the conflicts. Mother is proud of accomplishments and interests of the children, including ██████████ wanting to be a doctor, ██████████ wanting to be a child psychologist and writing poetry (even appearing on TV), and ██████████ being on the honor roll. ██████████ needs extra attention from mother. Mother tries to provide this in different ways, such as just taking ██████████ with her on an errand on the weekend. She tries to have individual time with all the children but especially ██████████ as he needs the one-on-one. ██████████ helps take care of his baby sister by every weekend making her breakfast by microwaving pancakes and sausage. ██████████ particularly likes to celebrate Christmas and his birthday because both make him very happy. ██████████ biological father is ██████████. He is also ██████████ and ██████████'s father. He has been in and out of ██████████'s life and the relationship has been complicated by various family dynamics. Family currently lives with ██████████'s father, ██████████ Bell, who mother has been involved with for six years. ██████████ coaches football at the same field where mother has gotten the children involved in sports. Mother's sister (██████████'s aunt) is ██████████, who is engaged to ██████████ (whom the kids refer to as uncle ██████████). They provide some support and assistance with the children, such as driving them to/from sports practices. ██████████'s godmother is ██████████. Family met her when ██████████ was six weeks old. She was a daycare provider where ██████████ attended as a baby. Godmother moved to New Jersey when ██████████ was four years old but is still actively involved with the family via phone. Mother describes godmother as key support for her and ██████████. Godmother has assisted mother in discussing things before making big decisions for ██████████, such as beginning medication and getting his ear pierced. Godmother sends ██████████ gifts for his birthday and Christmas. ██████████ spent last summer with his godmother in New Jersey and did many activities, including going to Disney.

##### Needs:

- ██████████ needs help with getting along with his siblings
- ██████████ help with decreasing aggression with siblings
- Family needs help with identifying positive, sustainable activities to engage in as a family.
- Mother needs help with strategies for intervening in sibling conflicts
- ██████████ needs help with ongoing opportunities for individual time with mother

#### Friends

##### Strengths:

██████████ states he has lots of friends at school. He also has friends in the neighborhood that he likes to play with outside. He gets along with friends at times and at times they have conflicts. Mother explains that she has some associates in town. Her close friend recently moved to Texas.

##### Needs:

- ██████████ needs help with continuing to develop peer relationships and interact appropriately with them.

#### Education

##### Strengths:

██████████ has always attended charter schools. He had previously attended Citizens Academy but now currently attends Hope Academy on Broadway where he is repeating the second grade. Transfer of schools was due in part to transportation issues. ██████████ likes math and feels that he is good at it. He is currently learning his times table. ██████████ is very good at writing cursive. ██████████ has made honor roll. ██████████ identified his teachers as his heroes because they help him. His teachers include ██████████, Ms. I., and Ms. H. Mother identifies that the assistant principal works well with ██████████. ██████████ does his homework when asked by mother. Mother or older sisters then check his homework. Mother tries to encourage ██████████ to read. ██████████ does have an IEP. He was evaluated in first grade at Citizens Academy and given an IEP. He attends regular education classes

and then receives pull out services with a special ed teacher. He was identified as needing I D services when he was at Citizens Academy. He is now in need of ED services. [REDACTED] has been suspended numerous times for behaviors such as fighting, kicking, and hiding from the security guard. [REDACTED] is escorted to class so that he does not run and hide around the school building. His current regular education teacher is Ms. B [REDACTED]. Mother has advocated with school to educate teacher as mother has had various experiences with teacher that have not been positive and had indicated that teacher does not seem to understand [REDACTED]'s disability and need/right for certain services. Mother has also information in case she needs to contact a child with disabilities advocate.

Needs:

- [REDACTED] needs help with managing his behaviors in school in order to not be suspended
- [REDACTED] needs help with remaining in his classroom and being in appropriate places at the appropriate times
- [REDACTED] needs help with following directions.
- Family needs help with advocating for appropriate interventions at school
- School staff needs help with education about [REDACTED]'s mental health needs. PRIORITY
- [REDACTED] needs help with improving his reading ability
- [REDACTED] needs help with writing manuscript.
- Family needs help with getting copies of IEP and EIR.

Emotional

Strengths:

Mother has sought mental health services through Beechbrook to assist [REDACTED]. He currently meets with Ms. G [REDACTED] for weekly therapy and appointments recently changed to Saturdays. [REDACTED] has been working with Ms. G [REDACTED] for about a year. [REDACTED] identified that Ms. G [REDACTED] has taught him that two wrongs don't make a right and to stop, relax, and think. Mother at times participates in therapy session and explained they recently read a book about bullying. Mother feels that Beechbrook has been helpful for [REDACTED] and for her as she feels that she has learned additional skills for how to help parent [REDACTED] and siblings, such as not dwelling on the negative. [REDACTED] previously had school based therapy services with Beechbrook when he attended Citizens Academy during first grade. There was a lapse during second grade at Citizens Academy, so mother sought outpatient therapy on her own.

Needs:

- [REDACTED] needs help with accepting when he does not win or not get what he wants
- [REDACTED] needs help with appropriately expressing and managing his emotions
- [REDACTED] needs help with sharing
- [REDACTED] needs help with controlling his anger as it escalates very high and needs help with calming down when angry. PRIORITY
- [REDACTED] needs help with telling the truth

Legal

Strengths:

[REDACTED] has not been involved in the legal system. Mother has made efforts to curb stealing behaviors and has imposed consequences when [REDACTED] does steal something, such as he does not get to keep it. Mother noted that [REDACTED] has been stealing less. Mother has even had a police officer that mother knew talk to [REDACTED] when he took a toy out of the cereal box at the store. Police officer explained possible consequences to [REDACTED] and/or mother.

Needs:

- [REDACTED] needs help with decreasing stealing behaviors and appropriately expressing his needs in order to have them met in appropriate ways

Financial

Strengths:

Mother works for [REDACTED] and has been there for five years doing retiree pay service. Changes are currently going on in the company and mother is in process of reapplying for her job in order to stay there. Mother's work schedule is changing June 1 to work 10am-6:30pm Monday through Friday. Mother has taken care of herself and her family and provided housing for herself since age 18. Mother has consistently paid bills but was injured when she broke her ankle in December and things piled up. Mother's wages are being garnished for a car note until June 2010. Mother has since had to get a van as car broke down in order to get family around. Mother has obtained FMLA for [REDACTED] (ADHD) and [REDACTED] (has severe asthma) in order to attend to their needs and various appointments.

Needs:

- Mother needs help with completing resume and re-application process in order to maintain her job and family's source of income.

PRIORITY

- Mother needs help with locating and accessing community resources to assist with family's needs

Safety

Strengths:

Mother feels that safety is very important and makes efforts to teach [REDACTED] and siblings about this. [REDACTED] identified rules that he has to follow when outside to stay safe, such as not playing in the street and not going to the store without mother. [REDACTED] has improved in keeping himself and siblings safe in the home compared to some past behaviors of physical harm to siblings and playing with fire.

Needs:

- [REDACTED] needs help with continuing to make choices to be safe for himself and when interacting with others in order to not cause

harm.

- [REDACTED] needs help with staying in boundaries when playing outside (not going off street) PRIORITY
- [REDACTED] needs help with staying with adults when out in the community or at school.

#### Recreation/Leisure

##### Strengths:

[REDACTED] has a variety of interests. He enjoys playing outside and riding his bike. He likes to watch TV, especially wrestling. He likes to play games and to go places. [REDACTED]'s favorite colors are red and blue. His favorite food is baked beans. Mother explains that family does activities during the summer together, such as going to the park, IX center, \$1 movies, and parties. Family used to have a tradition of every other weekend going out (such as movie and dinner) but has been limited by family's current financial situation as well as concerns about [REDACTED] disappearing while family is out in the community. Mother has enrolled [REDACTED] and all his siblings in summer camp at Lexington Bell near Fatima Center where [REDACTED] regularly goes to daycare. [REDACTED] attended that summer camp last year. He had some success and some trouble but staff was responsive to mother's education about [REDACTED]'s needs. [REDACTED]'s older sisters play softball. Mother has enrolled [REDACTED] in football again and is hopeful he will be able to participate this time. He will be playing for the [REDACTED] in the Muni League and practices at Michael Zone Rec Center. [REDACTED] coaches teams at that location.

##### Needs:

- Family needs help in identifying community resources for inexpensive/free family activities.
- [REDACTED] needs help with managing behaviors in order to participate in summer camp and football. PRIORITY

#### Spiritual

##### Strengths:

Mother states that family is Christian and believes in the Lord. She has had the children in church at various times. Currently family does not belong to a particular church. [REDACTED]'s older sisters would like to be baptized. Mother is trying to teach [REDACTED] and his siblings values, such as respecting each other, having a tight bond with family and importance of family, respecting adults outside the family, be good outside the home, the importance of education, and keeping kids on the right path.

##### Needs:

- Family has no identified needs at this time.

#### Medical

##### Strengths:

[REDACTED] sees Dr. E. [REDACTED] for psychiatry at Beechbrook. He currently takes medication to assist with his behaviors. He does not like the medication but does take it. Mother does not always give [REDACTED] medication on the weekends. If they are going out, however, she does give him the medication because it assists with managing his symptoms in the community. [REDACTED] has severe allergies. [REDACTED] receives medical care at the Broadway medical center with Dr. M. [REDACTED]

##### Needs:

- [REDACTED] needs the ability to get a drink of water or have a mint regularly as his mouth gets dry and white appears around his mouth as a side effect of his medication.
- [REDACTED] needs help with maintaining regular psychiatric and medical appointments.

#### Residence

##### Strengths:

[REDACTED] and his family are currently living with mother's boyfriend (youngest sister's father). Family has been living here for approximately a year. Previously, the family lived in a single family home with four bedrooms near Wade Park for two years through Cleveland Housing Network (CHN). [REDACTED] and his brother shared a room at that home. Family currently is very limited on space as they are sharing a home. The CHN home was broken into multiple times. Mother made efforts to have CHN fix and secure the home, but CHN did not follow through. Mother was concerned about family's safety and determined that family could no longer live there. At that time, family moved in with boyfriend and put many of the family's belongings in storage. Mother is currently on waitlist for CHN as several confusions have occurred over the process of getting a new house. Mother very much wants family to have own house and to have a safe haven for her family to rest in. Mother wants children to have separate bedrooms in order to have their own space, which mother feels would decrease conflicts in the family.

##### Needs:

- Mother needs help with advocating with CHN regarding housing. PRIORITY
- Mother needs help with exploring and identifying other possible community resources for housing. PRIORITY
- Family needs help with developing strategies for managing and getting along in current limited space. PRIORITY

#### Vision

Child: [REDACTED] wants to be a police officer when he grows up.

Caregiver: Mother wants stability for the family (particularly for family to have their own house), for the kids to all get along, for [REDACTED] to overcome bad things (such as his sticky fingers), and for [REDACTED] to be more able to calm himself down.

#### Possible team members

- [REDACTED] -- youth
- [REDACTED] -- mother
- [REDACTED] -- father

- ██████████ -- De'Asia's father
- ██████████ -- godmother
- ██████████ -- aunt
- ██████████ -- uncle
- ██████████ -- mother's friend
- ██████████ -- mother's friend
- ██████████ -- Beechbrook therapist
- ██████████ -- Beechbrook psychiatrist
- ██████████ -- teachers
- Sarah Hays -- Tapestry care manager
- ██████████ -- parent support partner
- ██████████ -- parent advocate

Summary of Priority Needs for ██████████ as of June 2, 2009

- School staff needs help with education about ██████████'s mental health needs
- ██████████ needs help with controlling his anger as it escalates very high and needs help with calming down when angry
- Mother needs help with completing resume and re-application process in order to maintain her job and family's source of income.
- ██████████ needs help with staying in boundaries when playing outside (not going off street).
- ██████████ needs help with managing behaviors in order to participate in summer camp and football
- Mother needs help with advocating with CHN regarding housing.
- Mother needs help with exploring and identifying other possible community resources for housing.
- Family needs help with developing strategies for managing and getting along in current limited space

# ADDENDUM E

# Plan of Care

# Form 1 – DSM Diagnosis

Diagnosed By		Diagnosis Date	
Current Grade	Spelling Level		
GPA	Full Scale IQ	IQ Range (see list)	1 Cognitively Deficient 2 Borderline Deficient 3 Below Average 4 Average 5 Above Average 6 Superior 7 Very Superior
Reading Level	Verbal IQ	IQ Range (see list)	
Math Level	Non-Verbal IQ	IQ Range (see list)	
Axis I			
DSM	Primary	Rule Out	Comment
1			
2			
3			
4			
5			
6			
Axis II			
DSM	Primary	Rule Out	Comment
1			
2			
3			
4			
5			
6			
Axis III – Medical Condition			
Axis IV – Life Stressors			
Axis V – GAF Score			

# Plan of Care

# Form 2 – Strengths & Vision

Strengths	Community Resource?
1	Y / N
2	Y / N
3	Y / N
4	Y / N
5	Y / N
6	Y / N
7	Y / N
8	Y / N

Family Vision

# Plan of Care

# Form 3 – Needs

Domains – Circle all that apply									
AODA	Cultural/Spiritual	Educational/Vocational	Family	Legal	Living Situation	Medical	Mental Health		
Safety/Crisis		Social/Recreational		Systems Barriers		Transitional Planning		Other	
Need Text									
Start Date			Anticipated Achievement Date			Initial Ranking (1-5)			
Strengths – Circle all that apply	1	2	3	4	5	6	7	8	
Strategies									
Text						Person(s) Responsible			
1									
2									
3									
4									
5									
6									

Domains – Circle all that apply									
AODA	Cultural/Spiritual	Educational/Vocational	Family	Legal	Living Situation	Medical	Mental Health		
Safety/Crisis		Social/Recreational		Systems Barriers		Transitional Planning		Other	
Need Text									
Start Date			Anticipated Achievement Date			Initial Ranking (1-5)			
Strengths – Circle all that apply	1	2	3	4	5	6	7	8	
Strategies									
Text						Person(s) Responsible			
1									
2									
3									
4									
5									
6									

# Plan of Care

## Form 4 – Reactive Crisis Plan

Crisis Plan Date
Crisis Plan Elements
Interests and Strengths of the Client Relevant to Crisis Situation
Risk and/or Triggers Relevant to Crisis Prevention/Safety
Specific Effective techniques in Resolving Crisis
What Helps the Caregiver
Family and Community
Resources to use in crisis situation
Relevant Medical Information



# Plan of Care

# Form 6 – General Information

Current POC Date	POC Number	Create Date
Next Meeting Information		
Next POC Date	Next POC Time	Location
Next Team Meeting Date	Next Team Meeting Time	Next Team Meeting Location
Court Information		
Permanency Plan (circle one)		
Return Home	TPR/Adoption	Adoption
Sustaining Care	Relative Placement	Foster Care
Independent Living	Not Applicable	
Court Orders		

School Information		
School Name		
Contact Person	Phone Number (XXX) XXX-XXXX Ext XXX	Grade
Special Education (circle all that apply)	IEP Done?	IEP Date
ED   LD   CD   OHI   N/A	Yes   No   Unknown	
Relevant Medical Information		

Note – Insert additional copies of Form 5 – Medication Information if appropriate

# Plan of Care

Health Care Provider Information												
Faith Affiliation Information												
Affiliated?				Yes	No	Unknown	Active?			Yes	No	Unknown
Faith Affiliation												
Faith Contact												
Developmental History												
Normal Developmental History?				Yes	No	Unknown	Sexually Active			Yes	No	Unknown
Concerns												
Psychiatric Hospitalization History												
Psychiatric Hospitalization History?				Yes	No	Unknown						
If 'Yes' describe												
Substance Use History												
Uses cigarettes?				Yes	No	Unknown	Prior History					
Uses alcohol?				Yes	No	Unknown	Prior History					
Uses drugs?				Yes	No	Unknown	Prior History					
If 'Yes' or 'Prior History' to any of the above describe												

**CONNECTIONS ISP/POC  
INDIVIDUAL SERVICE PLAN / PLAN OF CARE USER GUIDE**

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## CONNECTIONS ISP/POC INDIVIDUAL SERVICE PLAN / PLAN OF CARE USER GUIDE

### Using the [Action] Link to Create or Edit ISP/POCs

1. Click once on the Action: **DROP DOWN** list to select the *ISP-Connection Action*.

Action	Alpha	Class	Name	Edu. Dist.	DOB	SSN #	DOE
[Action]	ABER11		Jamela	08	7/25/1996		8/26/2009
							[OSParent (02/26/2010)] - [NOW] [OSWorker (02/26/2010)] - [NOW] [OSYouth (02/26/2010)] - [NOW] [ISPCON - 03/12/2010] [ISPTargetDate - 04/15/2010]
[Action]	ABERM1		, Matisha	08	12/17/1997		8/26/2009
							[OSParent (02/26/2010)] - [NOW] [OSWorker (02/26/2010)] - [NOW] [ISPCON - 01/04/2010] [OSYouth (02/26/2010)] - [NOW] [ISPTargetDate - 04/15/2010]

2. Click once on the [Action] **LINK** to the left of the Client where the Client's ISP/POC Information will be maintained. The following ISP/POC Summary Web Page will display.

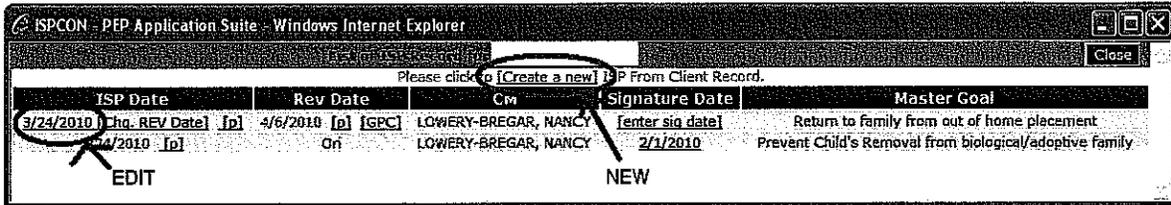
ISP Date	Rev Date	CM	Signature Date	Master Goal
3/24/2010 [Chg. REV Date] [p]	4/6/2010 [p] [GPC]	LOWERY-BREGAR, NANCY	[enter sig date]	Return to family from out of home placement
3/24/2010 [p]	Or:	LOWERY-BREGAR, NANCY	2/1/2010	Prevent Child's Removal from biological/adoptive family

3. To maintain the Client's ISP/POCs, Supervisor's Signature, or Client's ISP/POC Review information, refer to the section in this document as follows:

1. "Create or Edit ISP/POCs Through Client Information"
2. "Add or Delete Supervisor's Signature Dates"
3. "Add or Edit Client's ISP/POC Reviews"

## CONNECTIONS ISP/POC INDIVIDUAL SERVICE PLAN / PLAN OF CARE USER GUIDE

5. The following ISP/POC Summary Web Page will display.



6. To maintain ISP/POC, Supervisor's Signature, or Client's ISP/POC Review Information, refer to the section in this document as follows:

1. "Create or Edit ISP/POC Through Client Information"
2. "Add or Delete Supervisor's Signature Dates"
3. "Add or Edit Client's ISP/POC Reviews"

# CONNECTIONS ISP/POC INDIVIDUAL SERVICE PLAN / PLAN OF CARE USER GUIDE

## Basic Information Page

1. Review the information to be sure that it is correct.
2. Make the appropriate additions or corrections to the Basic Info Page and press the **Save** **BUTTON** to Update the Client's ISP/POC information.

### **CLINICAL NOTE:**

*To access the Treatment Recommendations from the Mental Health Assessment:*

1. Click once on the ALPHA ID LINK and the Client Basic Information web page will display.
2. Click once on the Associated Information DROP DOWN list and use the down arrow to display the Client Documents LINK.

*Open the Mental Health Assessment. The treatment recommendations are found on the second to the last page.*

### **CLINICAL NOTE:**

*The Priority Needs Identified by the Family can be found in your Strength, Needs, & Culture Document.*

3. Press the Service **BUTTON** to continue.

**NOTE:** The Main **BUTTON** will return user to the selection web page and can be used as an escape key to move out of a screen if needed.

## Service Page

To ADD or EDIT information for the following ISP/POC Services section follow the procedures listed below.

1. Once you have entered the Basic Information for the ISP/POC, click once on the Services **LINK** as shown below.

Mental Health Services Provided by PEP	Start Date	End Date	Frequency	Provider	Status
Partial Hospitalization					--
DTC/ECC CPST					--
Connections CPST	9/23/2009			WILSON, SUSAN	--
Pharmacologic Management					--

Other [Add Ser.] Services/Supports	Start Date	End Date	Frequency	Provider	Authorization Needed?	Requested Dates	Status
------------------------------------	------------	----------	-----------	----------	-----------------------	-----------------	--------

# CONNECTIONS ISP/POC INDIVIDUAL SERVICE PLAN / PLAN OF CARE USER GUIDE

## Lookup Other Services/Supports Providers

In order to select the Provider for Other Services/Supports that you are adding or updating, follow the steps below.

### **CLINICAL NOTE:**

*Informal Supports may be included in the Other Services/Supports if desired. An Informal Support must be included if being reimbursed through PEP Wraparound Funds.*

- Click once on the Provider **BUTTON** (e.g. double dots) to search and select a provider from the 'Name Contains:' **TEXTBOX**.

ISPCONService - PEP Application Suite - Windows Internet Explorer

Service:\* Education - Regular Education

If other or Specify, please provide additional info: \_\_\_\_\_

Status: In Progress

Start Date:\* 4/21/2010 End Date: \_\_\_\_\_ Frequency:\* 5 days week

Provider:\* 1000101 Bracksville/Broadview Hts School District

Auth Needed?  Yes  No Requested Dates: \_\_\_\_\_ to \_\_\_\_\_

Comments

**Note:** If you would like to display a list of all providers, key in a % sign and click Query. If a partial name does not display the Providers, shorten the name to see if the name is spelled differently (e.g. Beechbrook vs. Beech Brook.) Also, key in an acronym and long name of agency may also display more results (e.g. SOUTH EUCLID/LYNTHURST RECREAT & SELREC.) Trying both ways may avoid duplications.

- The following popup box will display.

Pep Vendor Lookup - Windows Internet Explorer

Please enter part of the vendor's name then click **Query** the database or select a Vendor from list below. You may **[clear]** the fields or click to **[Add a Vendor]**.

Name Contains: beech

177 - BEECH BROOK | BREECHBROOK (CLEVELAND, OH 44194-4140) [edit]

4675 - BEECHBROOK (CLEVELAND, OH 44124) [edit]

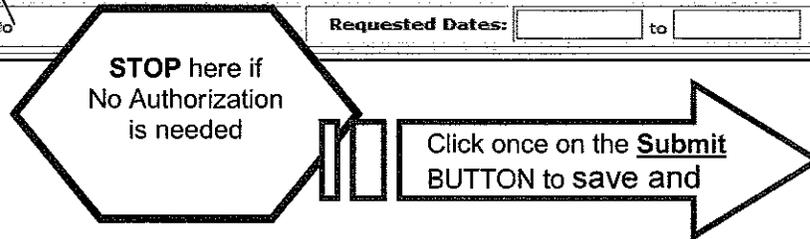
- Key in part of the name in the 'Name Contains' form field and click once on the Query **BUTTON** to display the names as shown above.
- When the Provider name displays, click once on the Provider Name **LINK**.
- The system will use the Provider number to populate the Provider **TEXTBOX** on the 'Other Services/Supports' webpage.

## CONNECTIONS ISP/POC INDIVIDUAL SERVICE PLAN / PLAN OF CARE USER GUIDE

- Fill in the Other Service/Support information through and including Authorization Needed.
- If Authorization Needed is a **No**:

The screenshot shows a web browser window titled 'ISPCONService - PEP Application Suite - Windows Internet Explorer'. The form contains the following fields:

- Service:** Education - Regular Education
- Status:** In Progress
- Start Date:** 4/21/2010
- End Date:** (empty)
- Frequency:** 5 days week
- Provider:** 100000 Brecksville/Broadview Hts School District
- Auth Needed?\***  Yes  No
- Requested Dates:** (empty) to (empty)



- If Authorization Needed is a **Yes**: Continue to fill out the remainder of this screen according to the following instructions:

### Completing and printing Wraparound Fund Request Form

- Click once on the Auth Needed? **RADIO BUTTON** Yes.

The screenshot shows a web browser window titled 'ISPCONService - PEP Application Suite - Windows Internet Explorer'. The form contains the following fields:

- Service:** Camp - Day
- Status:** Referral made; awaiting service
- Start Date:** 4/21/2010
- End Date:** (empty)
- Frequency:** daily
- Provider:** 39 BELIEVERS ACADEMY SUMMER CAMP
- Auth Needed?\***  Yes  No
- Requested Dates:** 7/1/2010 to 8/17/2010

#### **CLINICAL NOTE:**

*The **Requested Dates** refer to the dates the Wraparound Funds will be paying for this service. This differs from the Start Date. The **Start Date** is either the first date of this service or the date that the referral or request is being made.*

## CONNECTIONS ISP/POC INDIVIDUAL SERVICE PLAN / PLAN OF CARE USER GUIDE

Account: <input type="text"/>	Is 1915A Account? <input type="radio"/> Yes <input type="radio"/> No	Copay %: <input type="text"/>	
Category: <input type="text"/>	<input type="radio"/> One time expenditure <input type="radio"/> Recurring expense		
State how this service is provided:	Treatment goal(s): <input type="text"/>		
Is the service provided in the home?	source? <input type="radio"/> Yes <input type="radio"/> No		
Explain: effort needed without service:	arrangements, and long term plan to meet this need: <input type="text"/>		
Is this reimbursement request for services provided in the home?	No		
Does this require prior authorization from the ADAMHS Board? <input type="radio"/> Yes <input type="radio"/> No			
Cost/Unit: <input type="text"/>	Unit: <input type="text"/>	Total: <input type="text"/>	

### CLINICAL NOTE:

The definitions of the category can be found on the second page of the printed Wraparound Fund Request and below.

### SERVICE CATEGORIES:

1. **Emergency Family support and sustenance:** Items or funds to meet needs related to a client's health and safety. This includes, but is not limited to, any request for furniture or appliances or funding to pay for rent, utilities, phone, other immediate housing needs, or automobile repair  
ALWAYS REQUIRES PRIOR APPROVAL FROM ADAMHS Board
2. **Family support:** Items or services that provide daily living assistance to a child. This includes, but is not limited to, assistance to the family to allow a youth to participate in therapeutic activities (e.g. transportation) or remain in the community (e.g. after school supervision)
3. **Therapeutic services:** Items, services or activities to promote symptom management. This includes, but is not limited to, services such as: expressive or specialized therapies, respite care in or out of home, a bilingual therapist or family preservation and items such as: art supplies, journal, meditation books, stress ball, and exercise equipment
4. **School-related services:** Items or services to promote successful functioning in school. This includes, but is not limited to, services such as tutoring, and items or fees to allow participation in class/school activities related to service plan goals
5. **Medical Services:** Items or services to address co-occurring medical issues. This includes, but is not limited to, services such as: repairing a scar on a child's face to improve self-esteem, tattoo removal, hiring someone for sex education, nutrition counseling, and weight management if related to the child's disorder
6. **Crisis Services:** Services to avert a crisis or stabilize a crisis situation. This includes, but is not limited to, services such as a safe home/shelter, a behavior aide at home, an alarm system, and environmental accommodations
7. **Independent Living Services:** Items or services to assist with developing skills to live independently. This includes, but is not limited to, items to establish an apartment, hiring a roommate, providing a weekly allowance, buying a transportation pass

## CONNECTIONS ISP/POC INDIVIDUAL SERVICE PLAN / PLAN OF CARE USER GUIDE

<b>Category:</b> <span style="border: 1px solid black; padding: 2px;">Interpersonal and recreational skill development</span> <input type="radio"/> One time expenditure <input type="radio"/> Recurring expense
<b>State how this expenditure relates to meeting the child's treatment goal(s):</b> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<b>Is the service or item requested available through any other source?</b> <input type="radio"/> Yes <input type="radio"/> No
<b>Explain: efforts to secure other funding, any shared funding arrangements, and long term plan to meet this need without paid wraparound services:</b> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<b>Is this reimbursement for out-of-pocket expenses?</b> <input checked="" type="radio"/> Yes <input type="radio"/> No
<b>Does this require prior authorization from the ADAMHS Board?</b> <input type="radio"/> Yes <input type="radio"/> No

**CLINICAL NOTE:**

*This question is asking if the recipient of this check has already paid for this service and is now being paid back. This is typically the PEP Connections CPST. This should be an unusual occurrence as the expectation is that the services are planned in advance.*

<b>Category:</b> <span style="border: 1px solid black; padding: 2px;">Interpersonal and recreational skill development</span> <input type="radio"/> One time expenditure <input type="radio"/> Recurring expense
<b>State how this expenditure relates to meeting the child's treatment goal(s):</b> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<b>Is the service or item requested available through any other source?</b> <input type="radio"/> Yes <input type="radio"/> No
<b>Explain: efforts to secure other funding, any shared funding arrangements, and long term plan to meet this need without paid wraparound services:</b> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<b>Is this reimbursement for out-of-pocket expenses?</b> <input type="radio"/> Yes <input type="radio"/> No
<b>Does this require prior authorization from the ADAMHS Board?</b> <input type="radio"/> Yes <input type="radio"/> No

**CLINICAL NOTE:**

*The criteria for Prior Authorization can be found on the second page of the Wraparound Fund Request and is printed below:*

**ADAMHS BOARD PRIOR APPROVAL CRITERIA:**

**PRIOR APPROVAL OF THE BOARD IS REQUIRED FOR THE FOLLOWING:**

- EMERGENCY FAMILY SUPPORT AND SUSTENANCE
- ANY USE OF WRAPAROUND FUNDS BEYOND ONE SERVICE PLAN QUARTER FOR ONE CHILD FOR ANY ONE SERVICE THAT COSTS IN EXCESS OF \$600 PER SERVICE QUARTER
- ANY REQUEST TO CONTINUE A SERVICE BEYOND ONE YEAR FOR A CHILD
- ANY REINFORCER IN EXCESS OF \$50 FOR ONE CHILD

# CONNECTIONS ISP/POC INDIVIDUAL SERVICE PLAN / PLAN OF CARE USER GUIDE

## ***Crisis Plan***

To ADD or EDIT information for the following ISP Crisis Plan section follow the procedures listed below.

1. Once you have entered the initial Basic Information section of the ISP/POC, click once on the Crisis Plan LINK.
2. The following webpage will appear.

3. To add a new Plan, click once on the [Add New Plan] LINK; otherwise, click on the Plan Date LINK to edit the Crisis Plan.
4. Enter the information into the **TEXTBOXES**.

Emergency Contact Name	Relationship	Phone
Jen Roberts	Aunt	740-213-0411
John Sample	Uncle	216-310-2009
Maureen Sample	Grandmother	440-711-4239
Patrick Sample	Grandfather	440-777-0183
Teri Maurer	CPST	216-361-9100

5. Click once on the Submit BUTTON to save the records and return to the Crisis Plan webpage.

# CONNECTIONS ISP/POC INDIVIDUAL SERVICE PLAN / PLAN OF CARE USER GUIDE

## NeedsSection

To ADD or EDIT information for the following ISP/POC Needs section follow the procedures listed below.

Once the Client's ISP/POC Web Page for a Client as shown below displays, follow the procedures below to Add or Edit ISP/POC Goals records.

1. When the Client's ISP/POC is displayed by ISP/POC Date, click once on the [\[ISP Date\]](#) LINK to open the Client's ISP/POC. Click once on the Add Need LINK to add a new Need.
2. The following Needs page will display. Key in the appropriate information and click once on the [Save](#) BUTTON to update the changes to the PEP Web Application.

ISPCON4 - PEP Application Suite - ISP - Windows Internet Explorer

ISP for 'FAYNQ1' DOB: 5/13/1993 (F) - ISP DATE: 4/21/2010

BASIC INFO | Services | Crisis Plan | Medication | **Add Need** | Save | Main

Client Need:

Type of Need:  Child's Mental Health Need as Identified in Mental Health Assessment and Outcome Measures  Other Identified Need

Jessica needs to eliminate aggression and decrease explosiveness.

Desired Results in Client's Words (Parent/Guardian as appropriate):

Jessica will not get into trouble when she is angry

**Note:** Once the initial Need is entered and saved, the lower part of the web page will display the Add Goals & Strengths List LINKS as shown below. Refer to the sections called 'ADD or EDIT ISP Goals' and 'ADD or EDIT Strength List' to add the Goals & Strengths to a desired Need.

Goal(s), objective(s) and Strategies [Add Goal] [Client's Strength List]

There are no goal entered for this Need yet.

3. **EDIT** → When the available ISP/POCs are displayed by ISP/POC Date, click once on the [ISPDate \(e.g. 1/23/2010\)](#) LINK to change the contents of the Client's ISP/POC.

**Note:** You will not be able to modify the ISP/POC, once a Supervisor's Signature date is entered for the ISP/POC.

4. Click once on an existing [Need \(X:Y:Z\)](#) LINK, where X=Number Of The Need, Y=Number Of The Goal, and Z=Number Of The Objective. See example below.

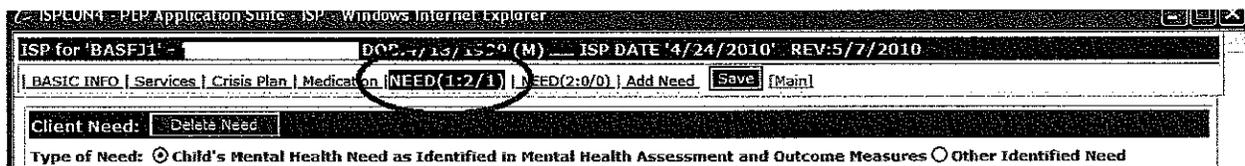
# CONNECTIONS ISP/POC INDIVIDUAL SERVICE PLAN / PLAN OF CARE USER GUIDE

## Add or Edit ISP/POC Goals

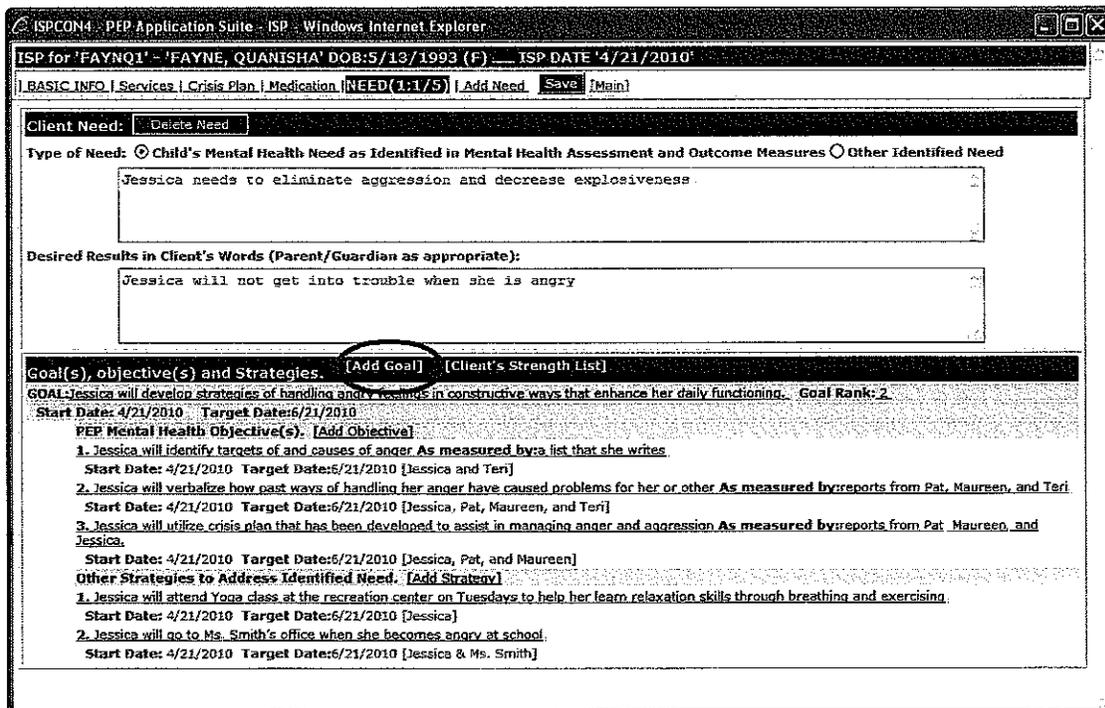
To ADD or EDIT goals for the Client's ISP/POC Need, follow the procedures listed below.

Once the Client's ISP/POC Need for a Client as shown below displays, follow the procedures below to Add the Client's ISP/POC Goals to a Need record.

1. **Add** → When the available ISP/POCs are displayed by ISP/POC Date, click once on the ISPDate (i.e. 1/23/2010) **LINK** to change the contents of the Client's ISP/POC.
2. Click once on an existing ISP Need **LINK** as shown below. The Need will be established before a goal can be loaded to the ISP/POC.



3. A sample of the edit Need screen shown on the next page will display when the ISPDate **LINK** and Need **LINK** are selected.



4. Click once on the Add Goal **LINK** to open the edit window.

## CONNECTIONS ISP/POC INDIVIDUAL SERVICE PLAN / PLAN OF CARE USER GUIDE

8. Click once on the Insert **BUTTON** to copy the strengths to the 'Strengths, Assets, and Supports.....' TEXTBOX. This saves the data entry of client strengths.
9. Once the Client's ISP/POC Goal has been entered or edited, click once on the Submit or Save **BUTTON** to save the changes to the PEP Web Application.

**Note:** Multiple Goals can be added to the Client's ISP/POC Need.

10. **Edit** → A sample of the Need with multiple Goals is shown below.

<a href="#">BASIC INFO</a>   <a href="#">Services</a>   <a href="#">Crisis Plan</a>   <a href="#">Medication</a>   <b>NEED (1:2/5)</b>   <a href="#">Add Need</a>   <a href="#">Save</a>   <a href="#">Main</a>
<b>Client Need:</b> <a href="#">Delete Need</a>
<b>Type of Need:</b> <input checked="" type="radio"/> <b>Child's Mental Health Need as Identified in Mental Health Assessment and Outcome Measures</b> <input type="radio"/> <b>Other Identified Need</b>
Jessica needs to eliminate aggression and decrease explosiveness.
<b>Desired Results in Client's Words (Parent/Guardian as appropriate):</b> Jessica will not get into trouble when she is angry
<b>Goal(s), objective(s) and Strategies.</b> <a href="#">Add Goal</a>   <a href="#">Client's Strength List</a>
<b>GOAL:</b> Jessica will develop strategies to handle angry feelings in constructive ways that enhance her daily functioning. <b>Goal Rank: 2</b> <b>Start Date:</b> 4/21/2010 <b>Target Date:</b> 6/21/2010
<b>PEP Mental Health Objective(s).</b> <a href="#">Add Objective</a>
<ol style="list-style-type: none"> <li>1. Jessica will identify targets of and causes of anger <b>As measured by:</b> a list that she writes.  <b>Start Date:</b> 4/21/2010 <b>Target Date:</b> 6/21/2010 [Jessica and Teri]</li> <li>2. Jessica will verbalize how past ways of handling her anger have caused problems for her or other <b>As measured by:</b> reports from Pat, Maureen, and Teri.  <b>Start Date:</b> 4/21/2010 <b>Target Date:</b> 6/21/2010 [Jessica, Pat, Maureen, and Teri]</li> <li>3. Jessica will utilize crisis plan that has been developed to assist in managing anger and aggression <b>As measured by:</b> reports from Pat, Maureen, and Jessica.  <b>Start Date:</b> 4/21/2010 <b>Target Date:</b> 6/21/2010 [Jessica, Pat, and Maureen]</li> </ol>
<b>Other Strategies to Address Identified Need.</b> <a href="#">Add Strategy</a>
<ol style="list-style-type: none"> <li>1. Jessica will attend Yoga class at the recreation center on Tuesdays to help her learn relaxation skills through breathing and exercising.  <b>Start Date:</b> 4/21/2010 <b>Target Date:</b> 6/21/2010 [Jessica]</li> <li>2. Jessica will go to Ms. Smith's office when she becomes angry at school.  <b>Start Date:</b> 4/21/2010 <b>Target Date:</b> 6/21/2010 [Jessica &amp; Ms. Smith]</li> </ol>
<b>GOAL:</b> Jessica will demonstrate the ability to listen and respond to the thoughts, feelings, and needs of others. <b>Goal Rank: 2</b> <b>Start Date:</b> 4/21/2010 <b>Target Date:</b> 6/21/2010
<b>PEP Mental Health Objective(s).</b> <a href="#">Add Objective</a>
There are no objectives for this goal.

# CONNECTIONS ISP/POC INDIVIDUAL SERVICE PLAN / PLAN OF CARE USER GUIDE

## Add or Edit ISP/POC Strategies

Once the Client's ISP/POC Goal have been added to the established ISP/POC Need, other strategies to address the need above and beyond the objectives can be entered. To ADD or EDIT ISP/POC strategies for each goal, follow the procedures listed below.

1. **Add or Edit** → When the available ISP/POCs Need is displayed, click once on the Add Strategy or Strategy Number (e.g. 1. Strategy Description) to enter or modify the Strategy related to each goal.

Goal(s), objective(s) and Strategies. [Add Goal] [Client's Strength List]

**GOAL:** Jessica will develop strategies of handling angry feelings in constructive ways that enhance her daily functioning. **Goal Rank:** 2  
**Start Date:** 4/21/2010 **Target Date:** 6/21/2010

**PEP Mental Health Objective(s):** [Add Objective]

1. Jessica will identify targets of and causes of anger **As measured by:** a list that she writes.  
**Start Date:** 4/21/2010 **Target Date:** 6/21/2010 [Jessica and Teri]

2. Jessica will verbalize how past ways of handling her anger have caused problems for her or other **As measured by:** reports from Pat, Maureen, and Teri.  
**Start Date:** 4/21/2010 **Target Date:** 6/21/2010 [Jessica, Pat, Maureen, and Teri]

3. Jessica will utilize crisis plan that has been developed to assist in managing anger and aggression **As measured by:** reports from Pat, Maureen, and Jessica.  
**Start Date:** 4/21/2010 **Target Date:** 6/21/2010 [Jessica, Pat, and Maureen]

**Other Strategies to Address Identified Need:** [Add Strategy]

1. Jessica will attend Yoga class at the recreation center on Tuesdays to help her learn relaxation skills through breathing and exercising.  
**Start Date:** 4/21/2010 **Target Date:** 6/21/2010 [Jessica]

2. Jessica will go to Ms. Smith's office when she becomes angry at school.  
**Start Date:** 4/21/2010 **Target Date:** 6/21/2010 [Jessica & Ms. Smith]

**GOAL:** Jessica will demonstrate the ability to listen and respond to the thoughts, feelings, and needs of others. **Goal Rank:** 2  
**Start Date:** 4/21/2010 **Target Date:** 6/21/2010

**PEP Mental Health Objective(s):** [Add Objective]

There are no objectives for this goal.

**Other Strategies to Address Identified Need:** [Add Strategy]

There are no Strategies for this goal.

2. The following web page will display.

ISP CON Objective - PEP Application Suite - Windows Internet Explorer

Cancel Submit Save Delete Objective

**Other Strategies to Address Identified Need-Review & Changes:\***

Jessica will attend Yoga class at the recreation center on Tuesdays to help her learn relaxation skills through breathing and exercising.

**Start Date:\*** 4/21/2010 **Target Date:\*** 6/21/2010

**Person Responsible:\*** Jessica

3. Click once on the Save or Submit **BUTTONS** to save the changes.

## CONNECTIONS ISP/POC INDIVIDUAL SERVICE PLAN / PLAN OF CARE USER GUIDE

4. To delete strengths, click once on the [del] LINK.
5. Click once on the Red X **BUTTON** to exit the Strength List webpage.

### ***Add or Delete Supervisor's Signature Dates***

To ADD or EDIT information for the Supervisor's Signature for an Initial ISP/POC or Review, follow the procedures listed below.

Follow the procedures below to Add or Edit ISP/POC Supervisor's Signature records once the Client's ISP/POC has been added to the system. The summary page as shown below will also allow you to Print the ISP/POC for a Client by ISP Date, as well as, Add, Edit, and Print the Client's ISP/POC Reviews associated with each ISP/POC Date.

ISP Date	Rev Date	CM	Signature Date	Master Goal
4/21/2010 [Chg. ISP Date] [Ip]	Ort	MAURER, TERI	[enter sig date]	Prevent Child's Removal from biological/adoptive family
3/24/2010 [Chg. REV Date] [Ip]	4/6/2010 [Ip] [GPC]	LOWERY-BREGAR, NANCY	[enter sig date]	Return to family from out of home placement
3/24/2010 [Ip]	Ort	LOWERY-BREGAR, NANCY	2/1/2010	Prevent Child's Removal from biological/adoptive family

1. **ADD** → To add the Supervisor's Signature Date to the Client's ISP/POC or the Client's ISP/POC Review, click once on the enter sig date **LINK** in the Sig Column and the following pop-up will appear. **Note:** The ISP/POC will lock the record.

**Explorer User Prompt**

Script Prompt:

Enter the parent's signature or completion date, once entered, this ISP will be locked. (1/1/1990) to unlock.

2. Key in a valid date (i.e. 4/1/2010) and Click the Ok **BUTTON** to add the date to the Client's ISP/POC or Review. **Note:** The parent date will show in the Date Signed column.

# CONNECTIONS ISP/POC INDIVIDUAL SERVICE PLAN / PLAN OF CARE USER GUIDE

## Adding / Editing ISP/POC Reviews

### Add or Edit Client's ISP/POC Reviews

When the initial ISP/POC has been written, the Rev Date COLUMN will show Ori, for Original. as shown below. To create an ISP/POC Review related to the Original ISP/POC, follow the procedures listed below.

**NOTE:** The Client's ISP/POC review should correlate to the active ISP/POC for a Client. For example, the Client's ISP/POC review of 5/7/2010 as shown below applies to the 4/24/2010 ISP/POC. In fact, the Client's ISP/POC review can only be entered after the Supervisor's Signature Date (#1) is entered.

The screenshot shows a web browser window with the title 'ISPCON PEP Application Suite - Windows Internet Explorer'. The main content area displays a table of ISP/POC records. The table has columns for 'ISP Date', 'Rev Date', 'CM', and 'Signature Date'. The first row shows an ISP Date of 4/24/2010, a Rev Date of 5/7/2010, and a Signature Date of 5/1/2010. The second row shows an ISP Date of 4/24/2010, a Rev Date of 5/7/2010, and a Signature Date of 5/7/2010. The third row shows an ISP Date of 4/24/2010, a Rev Date of 4/26/2010, and a Signature Date of 5/1/2010. The fourth row shows an ISP Date of 4/24/2010, a Rev Date of Ori, and a Signature Date of 4/24/2010. A pop-up dialog titled 'Explorer User Prompt' is overlaid on the table. The dialog contains a text input field with the number '3' and buttons for 'OK' and 'Cancel'.

ISP Date	Rev Date	CM	Signature Date	
4/24/2010 [p]	5/7/2010 [Add Rev] [p] [GPC]	LOWERY-BREGAR, NANCY	5/1/2010	Prev
4/24/2010 [p]	2 5/7/2010 [p]	LOWERY-BREGAR, NANCY	5/7/2010 1	Prev
4/24/2010 [p]	4/26/2010 [p]	LOWERY-BREGAR, NANCY	5/1/2010	Prev
4/24/2010 [p]	Ori	LOWERY-BREGAR, NANCY	4/24/2010	

1. **ADD** → To add the Client's ISP/POC Review, click once on the Add Rev LINK (#2) in the Rev Date Column. The Client's ISP/POC Review pop-up screen (#3) will appear to enter the new Revision Date.
2. Key in a Revision Date and click once on the Ok BUTTON.
3. The system will copy the prior ISP/POC Ori or prior ISP/POC review record to a new ISP/POC for modification.
4. Refer to the 'Creating / Editing The ISP/POC' section for information on how to add modify the client ISP/POC.

**Note:** You will not be able to modify the ISP/POC, once a Supervisor's Signature date is entered for the ISP/POC.

# CONNECTIONS ISP/POC INDIVIDUAL SERVICE PLAN / PLAN OF CARE USER GUIDE

4. When the associated review web page displays, in addition to any modifications related to the ISP/POC, the **Need** area shown in red below will need to be filled in for reviews.

ISPCON4 - PEP Application Suite - ISP - Windows Internet Explorer

ISP for 'FAYNQ1' - 'FAYNE, QUANISHA' DOB:5/13/1993 (F) — ISP DATE '4/21/2010' REV:6/1/2010

BASIC INFO | Services | Crisis Plan | Medication | **NEED(1:2/5)** | NEED(2:1/1) | Add Need | Save | Main

Client Need:

Type of Need:  Child's Mental Health Need as Identified in Mental Health Assessment and Outcome Measures  Other Identified Need

Jessica needs to eliminate aggression and decrease explosiveness.

Desired Results in Client's Words (Parent/Guardian as appropriate):

Jessica will not get into trouble when she is angry

Need Review Progress Note (Include a statement of progress, achievement, or barriers to progress for each goal under this Need Statement)

5. When the associated review web page displays, in addition to any modifications related to the ISP/POC, the **Goal** area shown in red below will need to be filled in for reviews.

ISPCONGoal - PEP Application Suite - Windows Internet Explorer

Cancel Submit Save Delete Goal

Goal:\*

Jessica will develop strategies of handling angry feelings in constructive ways that enhance her daily functioning.

Start Date:\* 4/21/2010 Target Date:\* 6/21/2010 End Date: Status: --

If Discontinued, Specify the Reason:

TODAY, how would we rate the progress toward reaching this goal on a scale of 1 to 5?  
(As a team, rate this from the family's perspective with 1 meaning completely unmet to 5 meaning met to the family's satisfaction)  1  2  3  4  5 **REQUIRED**

Strengths, Assets, and Supports and how they will be used to meet this goal.\* Str. List

Jessica's grandparents are very patient with her and are willing to work with Jessica to better manage her anger.  
Jessica loves her grandparents and wants to please them, so she is willing to work on her anger.

# CONNECTIONS ISP/POC INDIVIDUAL SERVICE PLAN / PLAN OF CARE USER GUIDE

## Printing ISP/POC Documents

### Printing The ISP/POCs

The ISP/POC web pages contain a useful Print LINK to allow the user to print the Client's ISP/POC or the Client's ISP/POC Review. (Please see the 2 locations to do a print preview below.)

ISP Date	Rev Date	CM	Signature Date	Master Goal
4/21/2010 [Chg. ISP Date] [p]	On	MAURER, TERT	[enter sig date]	Prevent Child's Removal from biological/adoptive family
3/24/2010 [Chg. REV Date] [p]	4/1/2010 [p] [GPC]	LOWERY-BREGAR, NANCY	[enter sig date]	Return to family from out of home placement
3/24/2010 [p]	On	LOWERY-BREGAR, NANCY	2/1/2010	Prevent Child's Removal from biological/adoptive family

1. Click once on the [p] **LINK** that appears to the right of the Client's ISP/POC Date Column to print the Client's ISP/POC Report.

**NOTE:** This process will print one ISP/POC for the selected date and Client.

2. When the print preview window appears, Click once on the File / Print MENU and Click once on the Ok **BUTTON** to route the document to the printer.

### Printing The ISP/POC Reviews

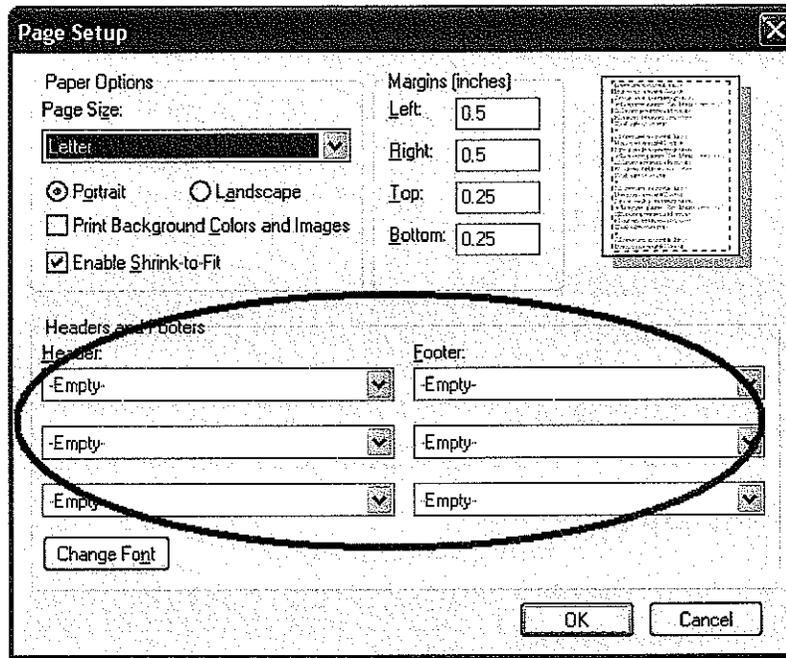
1. Click once on the [p] **LINK** that appears to the right of the Rev Date Column to print the Client's ISP/POC Review Report.

**NOTE:** This process will print one Client ISP/POC Review for the selected date and Client.

2. When the print preview window appears, Click once on the File / Print MENU and Click once on the Ok **BUTTON** to route the document to the printer.

## CONNECTIONS ISP/POC INDIVIDUAL SERVICE PLAN / PLAN OF CARE USER GUIDE

4. **For IE8:** Go to the section in the middle of the Page Setup window marked **Header** and **Footer** and use the drop down to remove any entry so that the fields are left **-Empty-**.



5. Go to the section at the **Margins (inches)** area of the Page Setup window and set the margins to **.5** for left and right and **.25** for top and bottom.
6. Click the **Ok** **BUTTON** to save the changes.

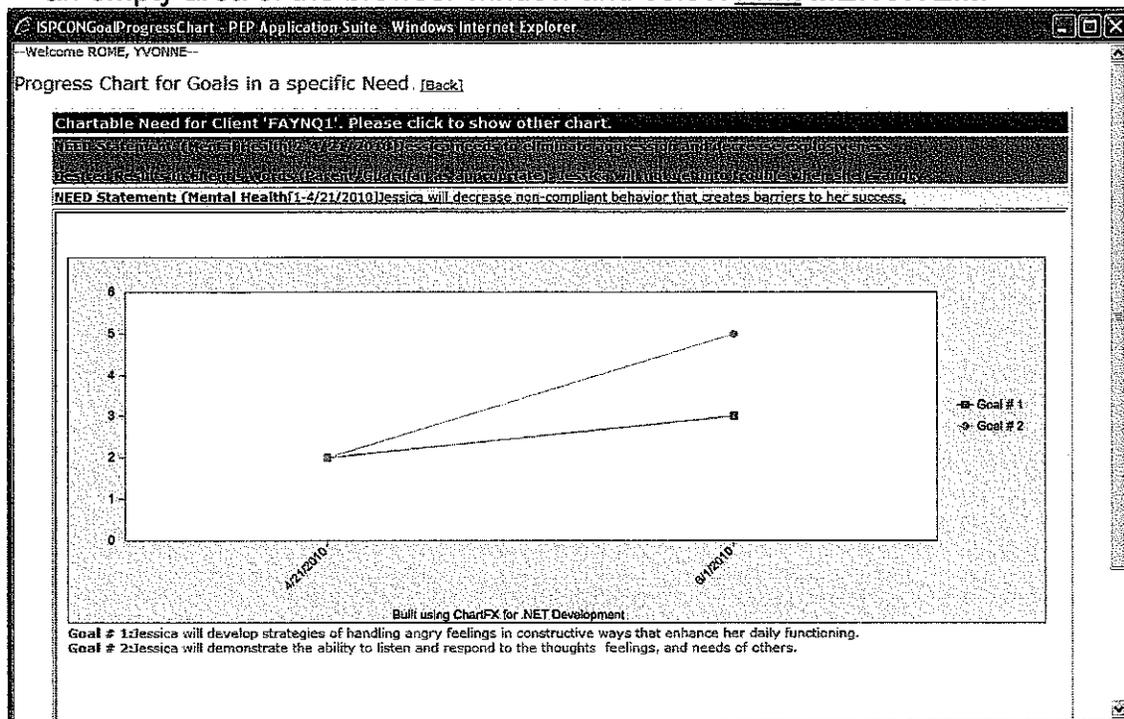
**NOTE:** The settings for one half inch (.5) on the left and right margins and one quarter inch (.25) on the top and bottom margins should accommodate the reports for most printers.

# CONNECTIONS ISP/POC INDIVIDUAL SERVICE PLAN / PLAN OF CARE USER GUIDE

## Printing The GPC (Goal Progress Chart)

The ISP/POC Review web pages contain a useful [\[GPC\] LINK](#) to allow the user to print the Client's ISP/POC Review progress in Chart Form as shown below.

1. Once you have displayed the desired GPC chart as shown below, right click on an empty area of the browser window and select **Print MENUITEM**.



2. Click once on the Print **BUTTON** to send you graph to the selected printer.

# ADDENDUM

## F



# Crisis Plan

Crisis Plan Date
Crisis Plan Elements
Family Definition of Crisis
Interests and Strengths of the Client Relevant to Crisis Situation
Risk and/or Triggers Relevant to Crisis Prevention/Safety
Specific Effective techniques in Resolving Crisis
What Helps the Caregiver
Family and Community
Resources to use in crisis situation
Relevant Medical Information



# ADDENDUM

## G

## What is the Family & Children First Council?

The Family and Children First Council (FCFC) is the county planning entity for promoting collaboration between the public systems, which serve children and families in Cuyahoga County.

In order to improve the functioning of children and to preserve the integrity of families in the community, the Cuyahoga County Family and Children First Council will develop a collaborate system for multi-need, multi-system children in Cuyahoga County.

Comprehensively addressing the service needs of families, the system will involve all major public and private agencies as needed.

### We have a team ...

The systems represented on the Service Coordination Team are:

Alcohol, Drug Addiction & Mental Health Services Board of Cuyahoga County (SCT)  
child system utilization gatekeepers are PEP Connections (Mental Health) and Catholic Charities (Alcohol and Drug Addiction Services),  
Child Support Enforcement Agency, Cleveland Metropolitan School District, Cuyahoga County Board of Developmental Disabilities, Cuyahoga County Employment and Family Services, Department of Children and Family Services, Department of Justice Affairs, Help Me Grow, Juvenile Court, Starting Point, and Tapestry System of Care.

### ... and people to help you.

Each system identified has a Service Coordination Team Liaison. They are the planners, coordinators, and navigators for a family-driven service coordination team process. They help the family's team identify strengths, needs and resources in systems & communities.

Service Coordination can be requested or suggested through:

- Your community
- Child-serving county systems
- Family & Children First Council



# Service Coordination

How families and caring professionals work together to keep children and teens healthy

What you need to know



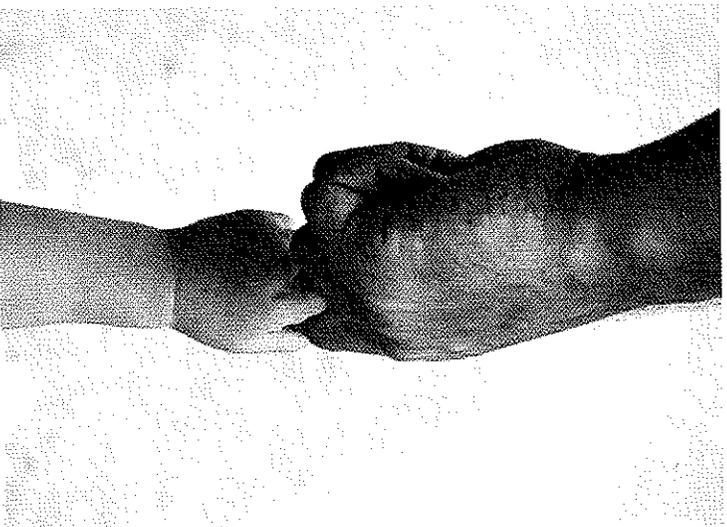
Your contact for more information:

Denise M. Pietrzak  
MSSA, LISW-S  
Program Officer 4  
Family & Children First Council

Office: 216-443-6115  
Mobile: 216-798-5260  
Fax: 216-698-2870  
dpietrzak@cuyahogacounty.us

For a services directory, visit [fcdc.cuyahogacounty.us](http://fcdc.cuyahogacounty.us).

# Service Coordination



## How It Works

In Cuyahoga County, Service Coordination is a *family-driven process* designed to bring services and supports to children and families in a manner that includes *family participation at every level.*

## Goals of Service Coordination:

### No Wrong Door:

Families are identified and linked to the appropriate systems and services no matter what door they enter.

### Lead system:

A system or community provider is designated as the lead to help families work with all of the members of the team.

### Coordinated Plan:

Different plans will be coordinated and in sync with each other.

## Who Does It Benefit?

### Families who:

are not system involved, but have a need (there are eligibility criteria for some systems/programs);

need assistance with navigation across systems;

are experiencing difficulties moving smoothly through the system processes;

have wishes that differ from what the system is offering;

have needs that outweigh the resources of one or more systems;

have encountered barriers within or between a system which may impede or disrupt the process;

are having difficulty accessing needed services or supports;

are involved with multiple systems and whose children are at risk of placement outside their home.

## Why Is It Necessary?

Some children and families get services from many providers.

Service Coordination:

Streamlines services to families

Promotes shared responsibilities

Reinforces collaborative values

Encourages accountability in achieving goals within a parent-driven process

Identification of gaps and barriers in available services and resources

It offers a formalized process with written procedures and establishes a format to resolve questions or conflicts.

## What is Service Coordination?

Service Coordination is a process for systems and community providers to link families to the necessary services and resources through a family driven team process.

## What is the purpose of Service Coordination?

To prevent multi-system involved children and their families who may be in crisis from falling between the cracks-due to intake/eligibility, or funding barriers.

# Family Voices. Smart Choices.

# ADDENDUM

# H



# SCT LIAISON CONTACT INFORMATION



Name	Title	Agency	Address	Phone	Email
Kevin Berg	Children's Program Specialist	Alcohol, Drug Addiction & Mental Health Services(ADAMHS) Board of Cuyahoga County	2012 West 25th Street Cleveland, Ohio 44113	216-241-3400 (W)	berg@adamhssc.org
Kristen Blaze	Program Manager	Department of Justice Affairs Clinical Services/Treatment Services	1276 W. 3rd St., Suite 210 Cleveland, Ohio 44113	216-443-3756 (W) 216-224-3570 (C) 216-348-4800 (F)	kblaze@cuyahogacounty.us
Maura Coyne Lipinski	Connections Program Director	PEP	3134 Euclid Ave. Cleveland, Ohio 44115	216-361-9100 (W) 216-361-7774 (F)	mcoynelipinski@pepclave.org
Maureen Dee	Director of Youth Services	Catholic Charities Services	3135 Euclid Ave. Cleveland, Ohio 44115	216-391-2030 (W) 216-391-8946 (F)	medee@clevelandcatholiccharities.org
Mary Denihan	Senior Administrative Officer	Cuyahoga County Child Support Enforcement Agency	1640 Superior Ave. #70 Cleveland, Ohio 44114	216-443-5287 (W) 216-443-5366 (F)	denihm@odjfs.state.oh.us
Abbie Klein	UPK Regional Resource Coordinator	Starting Point-UPK	4600 Euclid Ave Suite 500 Cleveland, Ohio 44103	216-575-0061 (W) 216-575-0102 (F)	abbie.klein@starting-point.org
Kerry McAllester	Regional Manager	Cuyahoga County Board of Developmental Disabilities	Parma Developmental Center 6149 West 130th St. Parma, OH 44130	216-362-3779 (W) 216-299-7844 (C) 216-362-3700 (F)	MCALLESTER.KERRY@cuyahogabdd.org
Bonita-Rosalynne McKay	Executive Assistant	Starting Point	4600 Euclid Ave, Suite 500 Cleveland, Ohio 44103	216-575-0061 (W) 216-575-0102 (F)	bonita.mckay@starting-point.org
Myrtle Mitchell	Transition Coordinator	Help Me Grow	8111 Quincy Ave. Suite 344 Cleveland, Ohio 44104	(216) 698-5057 (W) (216)-698-2254 (F)	mmitchell@helpmegrow.org
Arlyce Nichols	Service Coordination Liaison	Cuyahoga County Department of Children and Family Services	3955 Euclid Ave, Room Cleveland, Ohio 44115	216-881-4176 (W)	nichoa01@odjfs.state.oh.us
Karen Ols	Program Administrator	Cuyahoga Tapestry System of Care	1400 West 25th Street, 4th Floor Cleveland, Ohio 44113	216-443-6127 (W) 216-780-0033 (C) 216-698-8969 (F)	kols@cuyahogacounty.us
Denise Pietrzak	Program Officer	Family and Children First Council	1801 St. Clair St. Cleveland, Ohio 44114	216-443-6115 (W) 216-798-5260 (C) 216-698-2870 (F)	dpietrzak@cuyahogacounty.us



# SCT LIAISON CONTACT INFORMATION



Name	Title	Agency	Address	Phone	Email
Mike Scherer	Children's Program Specialist	Alcohol, Drug Addiction & Mental Health Services (ADAMHS) Board of Cuyahoga County	2012 West 25th Street Cleveland, Ohio 44113	216-241-3400 (W)	scherer@adamhsc.org
Linda Torbert	Children's Program Administrator	Alcohol, Drug Addiction & Mental Health Services (ADAMHS) Board of Cuyahoga County	2012 West 25th Street Cleveland, Ohio 44113	216-241-3400 (W)	torbert@adamhsc.org
Demitra Turner	Social Worker	CMSD	Health & Social Services @ MLK 1651 East 71st Street Cleveland, Ohio 44103	(216) 218-1037 (W)	Demitra.M.Turner@cmsdnet.net
Van Ward	Placement Manager	Cuyahoga County Juvenile Court	3343 Community College Cleveland, OH. 44115	216-443-3107 (W) 216-443-2185 (F)	vward@cuyahogacounty.us
Adrienne Waugh	Center Manager	Cuyahoga County Employment and Family Services	Southgate NFSC 5398 1/2 Northfield Road Maple Heights, Ohio 44137	216-518-4801 (W) 216-581-4777 (F)	waugh@odifs.state.oh.us

## Alternates

Nadia Ibrahim	Quality Assurance Specialist	Help Me Grow	8111 Quincy Ave. Suite 344 Cleveland, Ohio 44104	216) 698-7687 (W) (216) 698-2254 (F)	nbrahim@helpmegrow.org
Eugenia Cash	Executive Director of Youth and Support Services/ Humanware External	Cleveland Metropolitan School District	1380 East 6th Street Cleveland, OH 44114	(216) 858-6539 (216) 858-6540 ( 216) 858-6502 (F)	eugenia.cash@cmsdnet.net
Tony Cook	SCT Alternate for Van Ward/Community	Cuyahoga County Juvenile Court	Metzbaum Center 3343 Community College Parma, Ohio 44115	(216) 698-6578 (W)	acccook@cuyahogacounty.us
Jill Koenig	SCT Alternate for PEP	PEP	3134 Euclid Ave. Cleveland, Ohio 44115	216-361-9100 (W) 216-361-7774 (F)	jillk@pepcleve.org
Barb Kohuth	SCT Alternate for Tim McDevitt Probation Systems	Cuyahoga County Juvenile Court	3343 Community College Avenue Cleveland, Ohio 44115	216-698-2708 (W) 216-310-4720 (C) 216-698-2737 (F)	bkohuth@cuyahogacounty.us
Nancy Lowery-Bregar	Connections Program Director	Positive Education Program	3134 Euclid Ave. Cleveland, Ohio 44115	216-361-9100 (W) 216-361-7774 (F)	nlowerybregar@pepcleve.org
Susan McHugh	Service Coordination Liaison/ SA Supervisor	Cuyahoga County Board of Developmental Disabilities	6149 West 130th Street Parma, Oh 44130	216-898-0033 (W) 216-299-8893 (C) 216-362-3700 (F)	mchugh.susan@cuyahogabdd.org

# ADDENDUM

I

## INTERAGENCY AGREEMENT

### BETWEEN THE FAMILY AND CHILDREN FIRST COUNCIL AND THE OFFICE OF EARLY CHILDHOOD

This Interagency Agreement (IA) is between the Family and Children First Council and the Office of Early Childhood for the Invest in Children Program. The purpose of the IA is to clarify the relationships between the above mentioned parties and define the roles and responsibilities of both parties as they relate to Help Me Grow of Cuyahoga County (HMG).

**WHEREAS**, the Family and Children First Council (hereinafter referred to as "FCFC") is the planning and policy entity for promoting collaboration between public systems which serves children and families in Cuyahoga County and develops the County's Child Well-Being Plan; and now FCFC desires the programmatic and fiduciary services of the Office of Early Childhood to develop, administer, coordinate and compensate public agencies and community-based organizations for the provision of early childhood services, including those services provided by HMG; and

**WHEREAS**, the Office of Early Childhood (hereinafter referred to as "OEC") administers Invest in Children (hereinafter referred to as "IIC"), Cuyahoga County's public/private partnership that aims to create a comprehensive system of care for children prenatal to Kindergarten entrance through the goals of effective parents and families; safe and healthy children; children prepared for school and a community committed to young children; and OEC has demonstrated its willingness and capability to administer the early childhood component of FCFC's Child Well-Being Plan; and

**WHEREAS**, Help Me Grow of Cuyahoga County (hereinafter referred to as HMG) is a statewide program responsible for administering services to families with children prenatal to three who meet the eligibility criteria as determined by the Ohio Department of Health and the Ohio Department of Job and Family Services. This includes families with children who are suspected or diagnosed with developmental delay or disability, and

**NOW, THEREFORE**, both parties agree as follows:

#### TERMS AND CONDITIONS:

##### **RESPONSIBILITIES OF FCFC:**

- 1 Working in collaboration with HMG, OEC and other stakeholders to assure that early childhood programs and services align to or compliment the County's Child Well-Being Plan
- 2 Selecting the administrative agent for HMG
- 3 Ensuring a Project Director for HMG
- 4 Preparing a Memorandum of Understanding (MOU) in partnership with OEC to provide basic oversight and direction for HMG
- 5 Approving the annual HMG application to the Ohio Department of Health
- 6 Approving the HMG budget at a full FCFC meeting
- 7 Receiving and approving the IIC strategic plan and budget, as a component of the Child Well-Being Plan, at a full FCFC meeting

- 8 Providing a dispute resolution process for children and their families receiving Part C services and a service coordination mechanism for at-risk children and their families receiving prenatal and ongoing services
- 9 Working in partnership with HMG to carry out the statutory requirements of the Child Abuse Prevention and Treatment Act (CAPTA) as they pertain to children birth to age three.
- 10 The FCFC Executive Director will serve as a member of the IIC Executive Committee and the HMG Personnel and Finance Committee.
- 11 Participating in biennial state HMG reviews and audits, including the preparation of FCFC minutes, MOU's and other relevant documents.
- 12 Authorizing the transfer of financial support for HMG services/programs: Prenatal Services, Newborn Home Visiting and Child Find, Part C- Early Intervention Services, At-Risk Services, and other programs as necessary.
- 13 Receiving and completing all funding transactions, including funds transfers (if applicable), timely issuance of funding allocation letters, etc upon receipt and any other relevant fiscal and/or programmatic report or information related to HMG programs and services.

**RESPONSIBILITIES OF OEC:**

- 1 Developing and monitoring County contracts with HMG
- 2 Developing administrative procedures that serve as oversight guidance to the HMG Program in partnership with the Educational Service Center, Administrative Agent for HMG, HMG Executive Director and other relevant stakeholders. This includes, at a minimum, the assurance of regular personnel and finance oversight committee meetings with OEC staff, the HMG administrative agent, HMG, FCFC and other stakeholders as appropriate
- 3 Providing oversight of HMG strategies and milestones through the development of meaningful and measurable performance standards and monitoring the effectiveness of service delivery by authorized child serving public agencies and/or community-based organizations for HMG.
4. Serving as the County oversight entity to HMG's Administrative Agent (Educational Service Center).
- 5 Developing/refining service delivery models, programs and services for families with children prenatal through three, in partnership with HMG, including prenatal home visiting, newborn home visiting, ongoing home visiting and service coordination (At-Risk and Part C), early childhood mental health, early learning and literacy services, and other services as funded by OEC
- 6 Providing program and fiscal management for prenatal home visiting, newborn home visiting, ongoing home visiting and service coordination (At-Risk and Part C), early childhood mental health, early learning and literacy services, and other services as funded by OEC.
- 7 Developing and strengthening partnerships with community organizations, other public systems, public officials, philanthropic and business partners, municipalities, school districts, hospitals, etc , and address barriers to accessing and receiving services.
8. Receiving, disbursing and monitoring funds, and providing administrative services for prenatal home visiting, newborn home visiting, ongoing home visiting and service coordination (At-Risk and Part C), early childhood mental health, early learning and literacy services, and other services as funded by OEC in accordance with state, federal and local laws and directives, policies and practices of the Board of County Commissioners (BOCC), FCFC, the Ohio Department of Health (ODH), the Ohio Department of Job and Family Services (ODJFS), and applicable Federal Departments

9. Assisting HMG with purchasing/procuring client or administrative services and/or entering into contracts with approved community-based providers to deliver prenatal home visiting, newborn home visiting, ongoing home visiting and service coordination (At-Risk and Part C), early childhood mental health, early learning and literacy services, and other services as funded by OEC OEC shall receive invoices for services rendered, review them for accuracy and make timely payments for appropriate services
10. Establishing or participating in the implementation of quality assurance procedures following established protocols for referral, assessment, and service delivery Assist HMG in developing corrective action plans for under performing agencies
11. Preparing and submitting quarterly fiscal reports and bi-monthly program updates to FCFC relative to the Invest in Children Program, which is inclusive of services and programs provided by HMG, as well as other reports as needed or requested
12. Participating, as requested, in FCFC's evaluations, performance assessments, statistical reporting requirements and financial/programmatic audits performed by local, state and federal governments

#### **AGREEMENT VALUE**

1. The value of this Interagency Agreement to provide fiscal, administrative and client-related services of the Help Me Grow program, as funded by federal and state sources, shall not exceed up to the state and federal allocation in the aggregate over this two-year period at the levels presented in **Exhibit "A"**, which is attached hereto as an integral part of this agreement

#### **TIME OF PERFORMANCE**

1. This IA shall commence on July 1, 2007 and will remain in effect through June 30, 2010 unless revoked and/or cancelled in writing by either party as per the provisions contained in this IA

#### **AGREEMENT AMENDMENT**

1. The terms of this agreement including dates, services, and other provisions may not be changed, modified, discharged, or extended except by written amendment duly executed by the parties
2. All parties agree that no representation shall be binding upon any party hereto unless in writing

#### **AGREEMENT TERMINATION**

1. Either party may terminate this IA upon written notice of termination to the other parties at least thirty (30) days prior to the requested date of termination
2. Upon the expiration of thirty days after the service of the notice, the obligations of the party requesting termination under this IA shall cease
3. This IA may be terminated immediately in the event of loss of funding, breach of contract, significant financial/programmatic audit findings, disapproval by a state, federal or local administrative agency or upon discovery of noncompliance with any of the federal, state or local laws, rules or regulations

**NON-DISCRIMINATION**

- 1 FCFC and OEC agree to provide services without discrimination on account of race, sex, color, religion, national origin, age, occupation, physical or mental disability or veteran status, to the extent required by law and in accordance with Title VI of the Civil Rights Act of 1964
2. The parties agree that discrimination and affirmative action clauses contained in Executive Order 11246, as amended by Executive Order 11375, relative to relative to Equal Employment Opportunity for all persons without regard to race, color, religion, sex or national origin, and the implementing rules and regulations prescribed by the Secretary of Labor in Title 41, Part 60 or the Code of Federal Regulations, are incorporated herein to the extent binding upon approval by the Board of County Commissioners. Violations thereof shall be deemed a material breach of this Agreement.

**CONFIDENTIALITY**

- 1 Both parties agree that it shall not use any information, systems, or records made available for any purpose other than to fulfill the obligations specified herein
2. The parties agree to be bound by the standards of confidentiality that apply to their operations including, but not limited to, laws, statutes and regulations of the federal, state or local governments

**WITNESSETH WHEREOF**, the Cuyahoga County Board of County Commissioners, the Executive Office of Health and Human Services, the Family and Children First Council and the Office of Early Childhood have execute this Agreement on the \_\_\_\_ day of \_\_\_\_\_, 2008.

By: Robin R Martin 11/21/08  
Robin R Martin, Executive Director/Date  
Family and Children First Council

By: Richard B Werner  
Richard B. Werner, Deputy County Administrator/Date  
Office of Early Childhood

Digitally signed by  
James McCafferty  
Reason: I am approving this document  
Location:  
By: James McCafferty  
Resident/Date  
Cuyahoga County Board of County Commissioners

Digitally signed by:  
Saundra Curtis Patrick  
Reason:  
I am approving this document  
Location:  
Date: 12/10/08 15:44

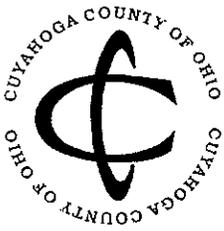
# ADDENDUM

J

**LOGIC MODEL WORKSHEET**  
SERVICE COORDINATION

INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES	IMPACTS	INDICATORS	ASSESSMENT TOOLS
<p><b>Resources:</b></p> <ul style="list-style-type: none"> <li>* SCT Members</li> <li>* Special Funding Support (i.e braided funding, FCSS, etc)</li> <li>* Agencies/Partners</li> <li>* Service Systems</li> <li>* Informal Supports</li> <li>* Family Members</li> <li>* Data Systems</li> <li>* Community Assistance Web-based System</li> <li>* Tier II Funding</li> </ul>	<ul style="list-style-type: none"> <li>* SCT Monthly meetings</li> <li>* SCT Subcommittee meetings</li> <li>* SCT quarterly meetings</li> <li>* Coordination of Services/Supports (phone calls, emails, face to face)</li> <li>* Meetings attended by SCT Liaisons</li> <li>* Ongoing Monitoring</li> <li>* Referrals internal and external</li> <li>* Education of Public and Partners</li> <li>* Communication to key persons of gaps and barriers to services</li> </ul>	<ul style="list-style-type: none"> <li>* No. of Families/youth served</li> <li>* No. of families served through community assistance</li> <li>* No. links to further supports/programs - to agencies or programs and for youth</li> <li>* No. hours spent coordinating</li> <li>* No. of Referrals generated - internal, external, formal and informal</li> <li>* Service plans</li> <li>* Gaps and barriers brought to attention of policy makers to resolve</li> </ul>	<ul style="list-style-type: none"> <li>* Ensure youth with multiple needs, &amp; multiple issues, &amp; involvement in multiple child serving systems &amp; their families get necessary services for family success</li> <li>* Coordination of care between system is seamless as possible</li> <li>* Families become independent of the system</li> <li>* Prevent or shorten future youth involvement in the system - JS and DCFS</li> <li>* Resolving gaps &amp; barriers to target youth/families</li> </ul>	<ul style="list-style-type: none"> <li>* Financial savings for adult systems</li> <li>* Healthier community</li> <li>* Positive PR impact for SC</li> </ul>	<ul style="list-style-type: none"> <li>* No. of youth who never enter system or shorten time in system</li> <li>* Reduction in no. of families dependent of system as appropriate</li> <li>* No. of families utilizing informal supports</li> <li>* Families with multiple need youth linked with correct services within a short time or effort</li> </ul>	<ul style="list-style-type: none"> <li>* Survey to families &amp; direct service providers on ease of linkage and identify gaps and barriers</li> <li>* DCFS, JC and ODYS data</li> <li>* Stratifying youth into levels of risk for levels of outcome</li> </ul>

# ADDENDUM K



COMMISSIONER  
Jimmy Dimora  
Timothy F Hagan  
Peter Lawson Jones

## **BUSINESS ASSOCIATE AGREEMENT**

We, the Cuyahoga County Family and Children First Council (FCFC) (“covered entity”) and Alcohol, Drug Addiction and Mental Health Services Board of Cuyahoga County (ADAMHSCC) and their contract vendors (“Business Associates”), Cuyahoga County Juvenile Court (“Business Associates”), Cuyahoga County Department of Children and Family Services (DCFS) (“Business Associates”), Cuyahoga County Department of Employment and Family Services (EFS) (“Business Associates”), Cuyahoga County Department of Senior and Adult Services (DSAS) (“Business Associates”), Help Me Grow of Cuyahoga County (“Business Associates”), Cuyahoga County Child Support Enforcement Agency (CSEA) (“Business Associates”), Cuyahoga County Board of Mental Retardation and Developmental Disabilities (MRDD) (“Business Associates”), and Starting Point (“Business Associates”) promote a collaborative system of care emphasizing coordination across a continuum of family-centered, neighborhood based, culturally competent services to ensure the well-being of every child, and to preserve and strengthen families in their communities.

The Cuyahoga County Service Coordination model is a navigation process designed to direct parents with children, prenatal through graduation, to appropriate services. It focuses on developing a coordinated and cooperative public system infrastructure that promotes cross system collaboration—at the policy, programmatic, and case levels.

We hereby agree to share information regarding the children and families of mutual concern, and to facilitate the development of regular communication and working relationships of staff at all levels through a web based database. The web based database will be maintained for the purpose of evaluation and outcomes. This evaluation will help to validate that service coordination is occurring across public systems in Cuyahoga County. As well as, show our effort and track the dollars spent in meeting the needs of youth and their families in the most appropriate least restrictive setting, which may result in short term placement.

### **Security Description**

With access via mobile devices, added security precautions have been added. The site is secured using Verisign's industry leading SSL certificates. The web server is explicitly set up to not allow any client to access the site without using SSL. We have created a series of secure links, which disguise any system-specific data within a long string of randomized data which is used to hide any data that may be used to enumerate the system. It is important to note that no sensitive data is transferred using this method. Instead, a record ID is sent, and once the server receives this ID, the requested data is retrieved and served to the mobile device. Also important to note is that the data still goes through the security checks as mention before.

Furthermore, depending on one's level of security, we can also assure that a given liaison can see as little or as much data as we wish. Each page includes a PHP function that is designed to

check the current user's security level against their agency's level and verify that the user is allowed to access the requested content. (Please see attachment for full description of the security settings)

The use of the Service Coordination Database is further constrained as follows:

### **Client Data Confidentiality**

By receiving client data in any form whatsoever from Family and Children First Council Services the parties to this agreement shall protect the confidentiality of said data as per the requirements of Ohio Administrative Code 5101:1-1-03 and 5101:1-37-01.01, the regulations promulgated by the United States Department of Health and Human Services (DHHS), the provisions of HIPAA, specifically 45 CFR 164.501, any amendments thereto, and as detailed below.

#### STATEMENT OF AGREEMENT

§1. HIPAA Compliance and Agents. Business Associate hereby agrees to fully comply with the "Business Associate" requirements under HIPAA, throughout the term of this Agreement. Further, Business Associate agrees that to the extent it has access to PHI, Business Associate will fully comply with the requirements of HIPAA and this Agreement with respect to such PHI; and, further, that every agent, employee, subsidiary, and affiliate of Business Associate to whom it provides PHI received from, or created or received by Business Associate on behalf of, Covered Entity will be required to fully comply with HIPAA, and will be bound by written agreement to the same restrictions and terms and conditions as set forth in this Agreement.

§2. Use and Disclosure; Rights. Business Associate agrees that it shall not to use or disclose PHI except as permitted under this Agreement or as required by law. Business Associate acknowledges that this Agreement does not in any manner grant Business Associate any greater rights than Covered Entity enjoys, nor shall it be deemed to permit or authorize Business Associate to use or further disclose PHI in a manner that would otherwise violate the requirements of HIPAA if done by Covered Entity.

§3. Required or Permitted Uses. [6] Business Associate agrees that it is permitted to use or disclose PHI only: (a) upon obtaining the authorization of the patient to whom such information pertains in accordance with 45 C.F.R. §164.502(a)(1)(iv) and §164.508, (b) upon obtaining the consent of a patient to whom such information pertains, if the use or disclosure is for purposes of treatment, payment, or health care operations, in accordance with 45 C.F.R. §164.502(a)(1)(ii) and §164.506, or (c) without an authorization or consent, if in accordance with 45 C.F.R. §164.506, §164.510, §164.512, §164.514(e), §164.514(f), §164.514(g), or as otherwise permitted or required by agreement or law. [7]

§4. Safeguards; Location. Business Associate agrees to develop and use appropriate procedural, physical, and electronic safeguards to prevent misuse of PHI other than as provided by this Agreement. Business Associate agrees to notify Covered Entity of the

location of any PHI disclosed by Covered Entity or created by Business Associate on behalf of Covered Entity and held by or under the control of Business Associate or those to whom Business Associate has disclosed such PHI.

§5. Minimum Necessary. Business Associate must limit any use, disclosure, or request for use or disclosure to the minimum amount necessary to accomplish the intended purpose of the use, disclosure, or request in accordance with the requirements of HIPAA. Business Associate represents that all uses, disclosures, and requests it will make shall be the minimum necessary in accordance with HIPAA requirements. Covered Entity may, pursuant to HIPAA, reasonably rely on any requested disclosure as the minimum necessary for the stated purpose when the information is requested by Business Associate. Business Associate acknowledges that if Business Associate is also a covered entity, as defined by HIPAA, Business Associate is required, independent of Business Associate's obligations under this Agreement, to comply with the HIPAA minimum necessary requirements when making any request for PHI from Covered Entity.

§6. Records; Covered Entity Access. Business Associate shall maintain such records of PHI received from, or created or received on behalf of, Covered Entity and shall document subsequent uses and disclosures of such information by Business Associate as may be deemed necessary and appropriate in the sole discretion of Covered Entity. Business Associate shall provide the Covered Entity with reasonable access to examine and copy such records and documents of Business Associate during normal business hours. Business Associate agrees to fully cooperate in good faith with and to assist Covered Entity in complying with the requirements of HIPAA and any investigation of Covered Entity regarding compliance with HIPAA conducted by the U.S. Department of Health and Human Services ("DHHS"), Office of Civil Rights, or any other administrative or judicial body with jurisdiction.

§7. DHHS Access to Books, Records, and Other Information. Business Associate shall make available to DHHS its internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of, Covered Entity for purposes of determining the Covered Entity's or Business Associate's compliance with HIPAA.

§8. Designated Record Set; Individual Access. Business Associate shall maintain a designated record set, as defined by HIPAA, for each individual patient for which it has PHI. In accordance with an individual's right to access to their own PHI under HIPAA, Business Associate shall make available all PHI in that designated record set to the individual to whom that information pertains, or such individual's representative, all PHI in that designated record set, upon a request by such individual or such individual's representative.

§9. Accounting. Business Associate shall make available PHI or any other information required to provide, or assist in preparing, an accounting of disclosures in accordance with HIPAA.

§10. Report of Improper Use or Disclosure. Business Associate shall report to Covered Entity any information of which it becomes aware concerning any use or disclosure of PHI that is not provided for by this Agreement.

§11. Amendment of and Access to PHI; Notification. Business Associate shall make available PHI for amendment and shall incorporate any amendments to PHI accordingly. Business Associate shall make reasonable efforts to notify persons, organizations, or other entities, including other business associates, known by Business Associate to have received the erroneous or incomplete information and who may have relied, or could foreseeably rely, on such information to the detriment of the individual patient. Business Associate must update this information when notified by Covered Entity.

§12. Termination Rights [8] Business Associate acknowledges and agrees that Covered Entity shall have the right to immediately terminate this Agreement in the event Business Associate fails to comply with HIPAA requirements concerning PHI and the above requirements. This Agreement authorizes Covered Entity to terminate the Agreement, if Covered Entity determines, in its sole discretion, that Business Associate has violated a material term of the Agreement required by HIPAA.

§13. Breach or Violation; Knowledge. If Covered Entity knows of a pattern of activity or practice of Business Associate that constitutes a material breach or violation of Business Associate's obligations under this Agreement, Covered Entity shall take any steps reasonably necessary to cure such breach or end such violation, and, if such steps are unsuccessful, shall either (a) terminate this Agreement, if feasible, pursuant to §12, or (b) if termination is not feasible, report the breach or violation to DHHS. If Business Associate as a covered entity, defined by HIPAA, violates the terms and conditions of this Agreement in its capacity as a business associate of another covered entity, Business Associate will be in noncompliance with the standards, implementation specifications, and requirements of HIPAA.

§14. Return of PHI Business Associate agrees that upon termination of this Agreement, and if feasible, Business Associate shall (a) return or destroy all PHI received from, or created or received by Business Associate on behalf of, Covered Entity that Business Associate still maintains in any form and retain no copies of such information or, (b) if such return or destruction is not feasible, extend the protection of this Agreement to such PHI and limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

§15. Notices. All notices and other communications under this Agreement to any Party shall be in writing and shall be deemed given when delivered personally, telecopied (which is confirmed) to that Party at the telecopy number for that Party set forth at the end of this Agreement, mailed by certified mail (return receipt requested) to that Party at the address for that Party set forth at the end of this Agreement (or at such other address for such Party as such Party shall have specified in a notice to the other Parties), or delivered to Federal Express, UPS, or any similar express delivery service for delivery to that Party at that address.

§16. Non-Waiver. No failure by any Party to insist upon strict compliance with any term or provision of this Agreement, to exercise any option, to enforce any right, or to seek any remedy upon any default of any other Party shall affect, or constitute a waiver of, any Party's right to insist upon such strict compliance, exercise that option, enforce that right, or seek that remedy with respect to that default or any prior, contemporaneous, or subsequent default. No custom or practice of the Parties at variance with any provision of this Agreement shall affect or constitute a waiver of, any Party's right to demand strict compliance with all provisions of this Agreement.

§17. Gender and Numbers; Headings. Where permitted by the context, each pronoun used in this Agreement includes the same pronoun in other genders and numbers, and each noun used in this Agreement includes the same noun in other numbers. The headings of the various sections of this Agreement are not part of the context of this Agreement, are merely labels to assist in locating such sections, and shall be ignored in construing this Agreement.

§18. Counterparts. This Agreement may be executed in multiple counterparts, each of which shall be deemed to be an original, but all of which taken together shall constitute one and the same Agreement.

§19. Entire Agreement. This Agreement constitutes the entire agreement and supersedes all prior agreements and understandings, both written and oral, among the Parties with respect to the subject matter of this Agreement.

§20. Binding Effect. This Agreement shall be binding upon, inure to the benefit of and be enforceable by and against the Parties and their respective heirs, personal representatives, successors, and assigns. Neither this Agreement nor any of the rights, interests or obligations under this Agreement shall be transferred or assigned by Business Associate without the prior written consent of Covered Entity.

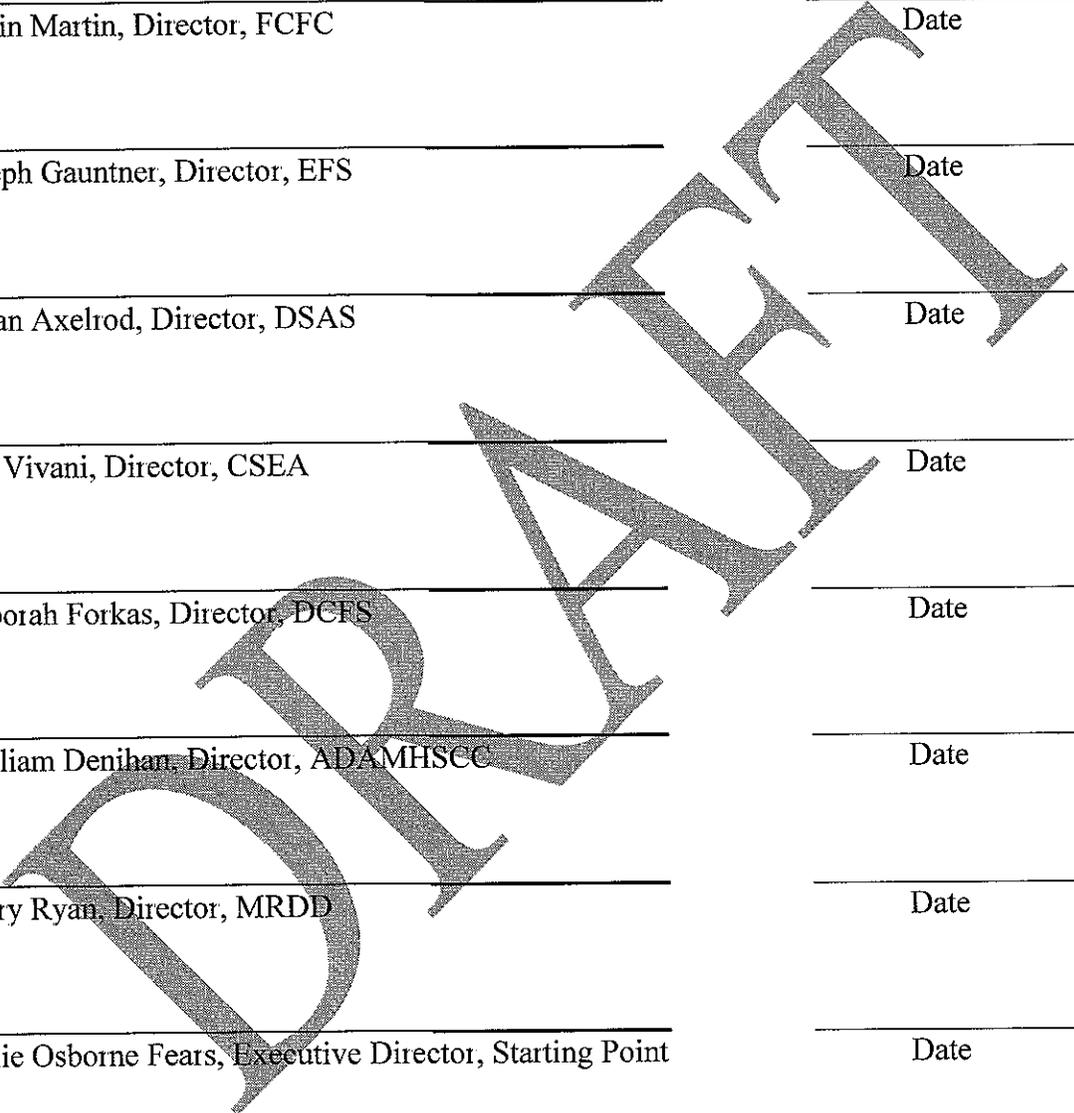
§21. Severability; Governing Law. With respect to any provision of this Agreement finally determined by a court of competent jurisdiction to be unenforceable, such court shall have jurisdiction to reform such provision so that it is enforceable to the maximum extent permitted by applicable law, and the Parties shall abide by such court's determination. In the event that any provision of this Agreement cannot be reformed, such provision shall be deemed to be severed from this Agreement, but every other provision of this Agreement shall remain in full force and effect. This Agreement shall be governed by and construed in accordance with the laws of the State of Ohio.

§22. Survival. All representations, covenants, and agreements in or under this Agreement or any other documents executed in connection with the transactions contemplated by this Agreement, shall survive the execution, delivery, and performance of this Agreement and such other documents.

§23. Further Assurances. Each Party shall execute, acknowledge or verify, and deliver any and all documents which may from time to time be reasonably requested by the other Party to carry out the purpose and intent of this Agreement.

This Business Associate Agreement (this "Agreement") is effective as of July 1, 2009. The agreement is entered in good faith and with the clear expectation that the intended collaboration will result in more effective interventions with children and families who are involved with children and families across the public systems named in this agreement.

_____ Robin Martin, Director, FCFC	_____ Date
_____ Joseph Gauntner, Director, EFS	_____ Date
_____ Susan Axelrod, Director, DSAS	_____ Date
_____ Jim Vivani, Director, CSEA	_____ Date
_____ Deborah Forkas, Director, DCFS	_____ Date
_____ William Denihan, Director, ADAMHSCC	_____ Date
_____ Terry Ryan, Director, MRDD	_____ Date
_____ Billie Osborne Fears, Executive Director, Starting Point	_____ Date
_____ Melissa Manos, Director, Help Me Grow	_____ Date
_____ Ken Lusnia, Court Administrator, Juvenile Court	_____ Date



Attachment:  
Full Security description for the Service Coordination Database

The SCT Database system was designed with confidentiality and security being top priority. In order to achieve a high level of security, while maintaining a satisfactory level of usability, all pages with sensitive content are built dynamically. Building pages dynamically allows one to check, with every access request, the level of security for the current user. The database stores information on which liaisons are associated with which agencies. A table within the database also keeps track of which children are assigned to which liaisons. By keeping track of which children are assigned to which liaisons, and given that we know with which agency a liaison is associated, we can make sure that only children associated with a liaison within an agency are able to be seen by other liaisons of the same agency.

With access via mobile devices, added security precautions have been added. Users cannot save their username or their passwords. The site is secured using Verisign's industry leading SSL certificates. The web server is explicitly set up to not allow any client to access the site without using SSL. In certain areas, the light web browser included with blackberries will not post data. Instead, we have created a series of secure links. These links disguise any system-specific data within a long string of randomized data which is used to hide any data that may be used to enumerate the system. It is important to note that no sensitive data is transferred using this method. Instead, a record ID is sent, and once the server receives this ID, the requested data is retrieved and served to the mobile device. Also important to note is that the data still goes through the security checks as mention before.

Furthermore, depending on one's level of security, we can also assure that a given liaison can see as little or as much data as we wish. Each page includes a PHP function that is designed to check the current user's security level against their agency's level and verify that the user is allowed to access the requested content. (Please see attachment for security settings for given roles)

Below is an outline of the security settings for given roles:

Role Non-placement  
Agency Type Non-placement  
Can only see children that are assigned to them.  
View all liaisons

Role Agency Admin  
Agency Type Non-placement  
Can see all children within the system.  
View all liaisons, and add/edit liaisons within own agency

Role Placement  
Agency Type Placement  
Can see all children within the system.

View all liaisons

Role Agency Admin

Agency Type Placement

Can see all children within the system

View all liaisons and add/edit liaisons within own agency

Role Super admin

Agency Type NA

User type in charge of the system. User can see any and all data, and can edit any and all child, agency and liaison data.

DRAFT

# ADDENDUM

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Date:

**Request For Special Funding for Residential Treatment Placement**

Demographic Information	
Client's Initials: <input type="text"/>	Client's Age: <input type="text"/>
UCI Number of Client: <input type="text"/>	Gender: Male or Female

**Specific Information Pertaining to Residential Placement**

**Please check one:**

- MH Residential
  AOD Residential
  Dual Residential

**Systems involved with the client:**

- ADAMHS
  CCDCFS
  Juvenile Court
  ODYS
  CCBDD  
 Tapestry/ SOC
  PEP/ Connections
  Catholic Charities  
 Post Adoption Special Services (PASS)

\* Has the youth been legally adopted? Yes or No

**Funding Source Being Requested:**

- Children's Reserve Fund
  Access to Better Care (ABC)

Agency Making Residential Referral:  PEP/ Connections  Catholic Charities

Primary Contact including phone number:

Residential Provider to be Utilized:

Day Rate of Placement: \$  Total Amount Requested: \$

Requested Date of Admission:

Amount of Days Requested :  30 Days  45 Days  60 Days  Other

1. **Rationale for Initial or continued Placement** (This should include rationale for requested length of stay e.g. medication stabilization, safety; focused short-term tx to stabilize behavior, # of prior treatment attempts, level of care justification).

2 **Services Provided Prior to Request for Residential Placement** (This will be prior treatment episodes and other community resources that have been used to help maintain the youth in the community)

3 **List treatment goals for initial and continued placement request:**

4 **Explain the family's commitment to treatment and their willingness to participate in treatment (Highlight if parents/guardians understand the requirement to attend meetings relative to progress and discharge planning)**

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*For ADAMHS Board Use Only*

**ADAMHS Board Determination**

**APPROVED**

**NOT APPROVED**

Rationale:

**Funding Source to be Utilized or Funding Breakdown for Shared Funding**