

York County Human Services

CASSP Child & Adolescent Service System Programming

100 W Market St, Suite B-129, York PA 17401

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yorkcountyhumanservices.org

(717) 771-9095



Child Name: _____ DOB: _____ MA Number (if applicable) _____

Home address: _____ Contact number: _____

School District: _____ Grade: _____ Building: _____

Mental Health Diagnosis (if known): _____ IQ: _____ above 70 _____ below 70 _____ unknown _____

Parent/Guardian Information:

Name: _____ Relationship: _____ Phone/Email: _____

Name: _____ Relationship: _____ Phone/Email: _____

Primary language of parent/guardian: _____ Primary language of student: _____

Is a translator able to be provided by school/organization? YES NO

Meeting availability: _____

Reason for referral (choose at least one): _____ Is mental health case management involved? YES NO

- School Attendance
- Educational Placement
- Behavior School
- Behavior Home
- Non-compliant
- Medical Issues
- Service Coordination
- More Services Needed
- Services Ineffective
- Team Planning
- Other: _____

Agency (if known): _____

Does student have a current IEP? YES NO

Please describe the behaviors or concerns which lead to making this CASSP referral:

Please list current services, if known:

What do you hope to accomplish through this CASSP meeting:

Person making referral: _____ Organization: _____ Phone/Email: _____

Committed to the belief that family has the potential to energize hope, guide change, and foster healing

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**YORK COUNTY HUMAN SERVICES – FAMILY ENGAGEMENT UNIT
CHILD AND ADOLESCENT SERVICE SYSTEM PROGRAM (CASSP), FAMILY GROUP DECISION MAKING (FGDM),
FAMILY TEAM MEETING (FTM)
INFORMATION RELEASE AND CONSENT FORM**

I hereby authorize York County Human Services Family Engagement Unit and the following organizations, **with whom I am currently working**, to release and receive information. Please list all services that are currently in place (i.e. School, School District, CYF, MH-IDD, SAM, JPO, Attorneys, Counseling Services, Etc.):

Professional's Name	Agency	Phone	Email

from the record of _____
Name Birthdate

Street Address City State Zip

School District School

Any or all of the following information may be exchanged for the purpose of referral/case coordination:

- | | |
|--|-------------------------------------|
| Psychiatric / Psychological reports | Vocational skills assessment |
| Teacher observations / School records | Social History / Family Information |
| Progress Reports | Attendance Data |
| Medical Reports | Report Cards |
| Neurological Reports | Admission / Discharge Reports |
| IQ test scores, aptitude and achievement tests | Behavior Reports |
| Human Services Department Information | |

This release is valid for 12 months from the date of signature and may be revoked by notifying a York CASSP Coordinator in writing or witnessed verbally. **I understand that treatment, payment, enrollment or eligibility for benefits and services is not subject to signing this release. However, I choose to sign this release voluntarily to receive CASSP coordination services. I have read this form carefully and understand what it means.**

Signature of Minor (age 14 and above) Date

Signature of Parent or Guardian Relationship Date

Signature of Witness Date

*** Signature of Witness Date

Verbal release of information (***)requires signature from two witnesses): This section is to be used for consumers who are unable to provide a signature. We have witnessed that the consumer understands the nature of this release and has freely given his/her consent.

In accordance with Pennsylvania Regulations: "This information has been disclosed to you from records whose confidentiality is protected by State Law. State regulations limit your right to make any further disclosure of this information without the prior written consent of the person to whom it pertains."