

Date: _____ Referral Type: Behavioral Health/Traditional Truancy

Referral Source: _____ Contact Person: _____ Phone#: _____

Referral Email Address: _____ Access/MA #: _____

Youth Name: _____ DOB: _____ Gender: _____

Parent Address: _____

Phone: (H): _____ (C) _____ (W) _____

Parent/Guardian/POA Name: _____ Phone: _____

Behavioral Health Diagnosis : _____

Medical Conditions/Physical Health Issues: _____

****Please attach the most recent evaluation signed by a psychiatrist or a licensed psychologist****

Other agency involvement: _____

Current MH Services: _____

Reasons for referral: _____

Release Signed	York/Adams HealthChoices	<input type="checkbox"/> Yes
by Youth/Family:	SAM/Joint Planning Team	<input type="checkbox"/> Yes
	Family Group Decision Making and CASSP	<input type="checkbox"/> Yes
Member Family Given Brochure on JPT		<input type="checkbox"/> Yes
Member Family Agree to Referral Submission		<input type="checkbox"/> Yes

Submit Referrals to:

York County Human Services
 100 West Market Street, Suite 401 York, Pennsylvania 17401
 (717) 771-9347 Fax: (717) 771-4663





YORK COUNTY HUMAN SERVICES DEPARTMENTS INFORMATION RELEASE FORM

I hereby authorize the following to release information to: _____ and/or to receive information from: _____

Service Access Management/Joint Planning Team

1305 E. Market St, York PA 17403

(Name and complete address of Agency/Individual)

(Name and complete address of Agency/Individual)

Regarding the Record of Name: _____ DOB: _____

Address: _____

The information released will be limited to any and all records requested below for the date range: _____

Please have consumer over 14 or person authorizing release of information sign their initials next to any requested information.

_____ Evaluation-Select: <input checked="" type="checkbox"/> Psychological	<input checked="" type="checkbox"/> Psychiatric	<input checked="" type="checkbox"/> Drug and Alcohol	<input type="checkbox"/> Offender	<input type="checkbox"/> _____
_____ Report Card/Attendance	_____ Behavior reports	_____ IEP/Evaluation Report	_____ Birth Certificate (copy)	
_____ Medical/Hospitalization Records	_____ Physical Exams	_____ Immunizations	_____ Dental Exams	
_____ Treatment Plan/Recommendations	_____ Progress Reports	_____ Attendance/Participation	_____ Discharge Summary	
_____ Probation/Parole Conditions	_____ Childline	_____ Drug Test Results	_____ Accurint/Family Finding	
_____ County Assistance/Welfare	_____ Pay Stub(s)	_____ Social Security Benefits	_____ Insurance Information	
_____ Residency Confirmation-Rent Payment, Lease or Mortgage _____				
_____ Financial Release-explanation: _____				
_____ Other: <u>JPT Referral</u> _____ Completed Referral filled out by Agency				

The information will be used for the following purpose(s): Assessment Provision of Service Referral Review

This release automatically expires **1 year from date of signature** or when the above-named person ceases to be a consumer of the agencies selected, whichever occurs sooner. The authorization for the release of information may be revoked at anytime. To revoke this authorization, please notify the York County Human Services Agency identified at the top of the release in writing.

I understand that I do not have to consent to the release of information. I understand that treatment, payment, enrollment or eligibility for services are *not* subject to signing this release, except as required to initiate County services. If health information is needed to initiate County services and I do not sign this release, I understand that I may not receive services.

I understand that there may be a risk that the person/organization receiving my information could possibly redisclose it without my authorization and then the confidentiality of the information might not be protected. I have read this form carefully and I voluntarily choose to release the information. I acknowledge that I fully and completely understand the content of this form.

Please read carefully:

- I have the right to receive a copy of this signed release form.
- If the consumer is 14 years of age or older, the consumer must sign and date the form.
- If the consumer is 14 years of age or younger, the consumer's parent or legal guardian must sign and date the form unless an exception exists under state or federal law.
- If the consumer is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship. Legal Guardian or Conservator Health Care Agent (Health Care Power of Attorney)

_____	<u>X</u> _____	_____	_____
Printed name	Signature of client/parent/guardian	Relationship	Date
_____	<u>X</u> _____	_____	_____
Printed name of staff	Signature of staff		Date

Notice to the recipient of these records

This information has been disclosed to you from records whose confidentiality is protected by State and Federal Law. Regulations limit your ability to make any further disclosure of this information without the prior written authorization of the person to whom it pertains.



YORK COUNTY HUMAN SERVICES DEPARTMENTS INFORMATION RELEASE FORM

I hereby authorize the following to release information to: _____ and/or to receive information from: _____

York/Adams HealthChoices Management Unit _____

100 West Market Street, York, PA 17401 _____

(Name and complete address of Agency/Individual)

(Name and complete address of Agency/Individual)

Regarding the Record of Name: _____ DOB: _____

Address: _____

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- _____ Evaluation-Select: Psychological Psychiatric Drug and Alcohol Offender _____
- _____ Report Card/Attendance _____ Behavior reports _____ IEP/Evaluation Report _____ Birth Certificate (copy)
- _____ Medical/Hospitalization Records _____ Physical Exams _____ Immunizations _____ Dental Exams
- _____ Treatment Plan/Recommendations _____ Progress Reports _____ Attendance/Participation _____ Discharge Summary
- _____ Probation/Parole Conditions _____ Childline _____ Drug Test Results _____ Accurint/Family Finding
- _____ County Assistance/Welfare _____ Pay Stub(s) _____ Social Security Benefits _____ Insurance Information
- _____ Residency Confirmation-Rent Payment, Lease or Mortgage _____
- _____ Financial Release-explanation: _____
- _____ Other: JPT Referral _____ Completed JPT Referral by Agency _____

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Printed name _____ X _____
Signature of client/parent/guardian Relationship Date

Printed name of staff _____ X _____
Signature of staff Date

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YORK COUNTY HUMAN SERVICES DEPARTMENTS INFORMATION RELEASE FORM

I hereby authorize the following to release information to: _____ and/or to receive information from: _____

Family Group Decision Making and CASSP _____

100 West Market Street, York, PA 17401 _____

(Name and complete address of Agency/Individual)

(Name and complete address of Agency/Individual)

Regarding the Record of Name: _____ DOB: _____

Address: _____

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Please have consumer over 14 or person authorizing release of information sign their initials next to any requested information.

_____ Evaluation-Select: <input checked="" type="checkbox"/> Psychological	<input checked="" type="checkbox"/> Psychiatric	<input checked="" type="checkbox"/> Drug and Alcohol	<input type="checkbox"/> Offender	<input type="checkbox"/> _____
_____ Report Card/Attendance	_____ Behavior reports	_____ IEP/Evaluation Report	_____ Birth Certificate (copy)	
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_____	X _____	_____	_____
Printed name	Signature of client/parent/guardian	Relationship	Date
_____	X _____	_____	_____
Printed name of staff	Signature of staff		Date

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Joint Planning Team

— for Youth and Families

What is the Joint Planning Team (JPT)?

A Joint Planning Team is not a service. It is a system of activities and a coordination of effort designed to help families, children, and youths with complex behavioral healthcare needs.

Members of a child's JPT will include family members and natural supports, as well as, service providers, case workers, and educational providers.

Who is Eligible?

Children and young people, from 11 to 21-years of age, with complex behavioral health needs and multi-system involvement. Eligible youth should also be in or at risk of out-of-home placement such as inpatient mental health services, residential treatment facilities, community residential rehabilitation or behavioral health rehabilitation services (BHRS).

What Does the JPT Do?

The JPT uses a support process to help families develop and use an individualized care program (ICP) to address the child's behavioral health needs and to restore a child to developmentally appropriate levels of functioning.

Who is on the JPT?

Facilitator - will support a child, their family, and other members of the JPT through the development and start of an individualized care plan.

Family Support Partners - are people with experience raising a child with complex behavioral health challenges. These JPT members will offer direct, non-clinical support to the parents.

Youth Support Partners - are similar to Family Support Partners. Youth Support Partners are young adults with personal experience in managing their own complex behavioral health challenges.

Supervisor - is a qualified mental health professional who oversees staff plans and work with families and youth.

Coach - provides direct support for Facilitators, Family Support Partners and Youth Support Partners.

Phases of the Individualized Care Program (ICP)

1. **Engagement** - The team meets to discuss the shared vision and teamwork vital to the process and the specific needs, strengths, and dynamic of the group.
2. **Planning** - The team creates the ICP. Youth and family should feel engaged, that they are heard, that the plan focuses on points upon which they wish to work, and that there is a reasonable chance that the ICP will help them meet their needs.

3. **Implementation** - The ICP begins. Progress and successes are continually reviewed and the plan is adjusted accordingly. This phase is repeated until the JPT's objective is achieved.

4. **Transition** - The team develops a plan to transition out of the formal program to a mix of family supports, community supports, professional services, and supports in the adult system, if necessary. The overall goal of the JPT is to make the JPT unnecessary. The preparation for transition away from the JPT is clear from the very beginning of the JPT process.

How Long Will the Process Take?

It takes time for families to improve their skills and establish their natural and community supports through the JPT process. JPT for each child varies in length between 6 to 18 months.

What is SAM, Inc.?

SAM, Inc. is a private non-profit organization providing intensive case management, resource management, blended case management, and peer rehabilitation services to children and adults under contract with York/Adams HealthChoices Management Unit.

Characteristics of the Individualized Care Plan

- The plan is developed by a family-centered team.
- The plan is individualized based on the strengths and culture of the child and their family.
- The plan is driven by needs rather than by services.

Ten Guiding Principals of the Individualized Care Plan

- Family Voice and Choice
- Team Based
- Natural Supports
- Collaboration
- Community Based
- Culturally Competent
- Individualized
- Strengths Based
- Persistence
- Outcome Based

Our MISSION

The mission of Service Access and Management, Inc. is to help people throughout Pennsylvania enhance the quality of their lives by effectively and efficiently managing and/or providing needed human services.

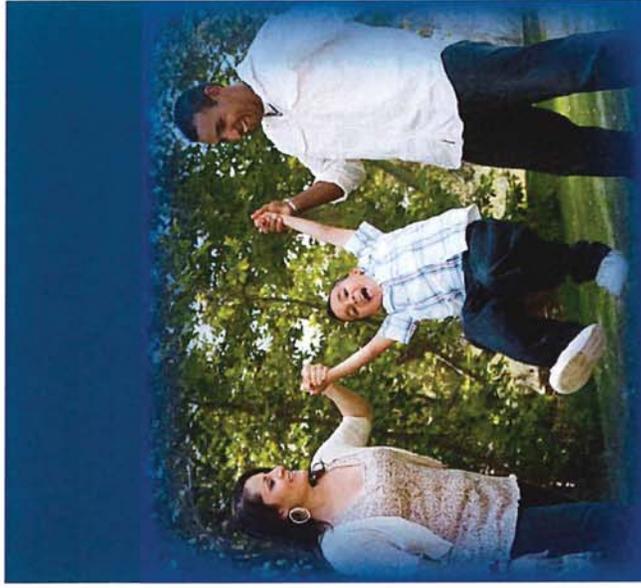
SAM, Inc., does not discriminate against persons because of their age, race, sex, religion, ethnic origin, disability, ancestry, national origin (including Limited English Proficiency), economic status, or sexual preference and shall observe applicable State and Federal Statutes and Regulations.

SAM, Inc. is the Joint Planning Team provider for the York County System of Care which is proud to be affiliated with the PA System of Care Partnership. www.pasocpartnership.org



Our OFFICE

York County
1305 E. Market Street, Suite B
York, PA 17403
717-848-8744



Joint Planning Team York County

