CASSP of Westmoreland County

Child & Adolescent Service System Program

CASSP MEETING REFERRAL FORM

Date: _____

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

FAMILY INFORMATION

CHILD

Last Name: _____ **First Name:** _____

Address: _____ **City:** _____ **State:** PA **Zip Code:** _____

School District: _____ **Age:** _____ **Grade:** _____

MOTHER / GUARDIAN

Last Name: _____ **First Name:** _____

Address: _____ **City:** _____ **State:** PA **Zip Code:** _____

FATHER / GUARDIAN

Last Name: _____ **First Name:** _____

Address: _____ **City:** _____ **State:** PA **Zip Code:** _____

Complete the following information in preparation of the CASSP meeting:

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

What domain of functioning is currently impacted?

- ☐ Academic
- ☐ Family / Home
- ☐ Social / Community

Is there a recent or current history of:				**Legal System Involvement:**	
	☐ Change in residence	☐ Physical Abuse			☐ Child Welfare
	☐ Child Neglect	☐ Sexual Abuse/Molestation			☐ Custody Courts
	☐ Domestic Violence	☐ Trauma			☐ Criminal Justice System
	☐ Emotional Abuse	☐ Other _____			☐ Juvenile Probation Svcs

Does the child have IEP? ☐ Yes ☐ No **Date of last IEP:** _____

Does the child have a 504 plan? ☐ Yes ☐ No **Date of last Plan:** _____

Revised April 27, 2020

Child's Diagnostic Information (Mental Health Diagnosis)

Child's Strengths

Child's Area(s) of Concern or Need

Current agency/agencies involved with the child/family

Service Utilization / Current or Prior Involvement						
					Date Svc Began	**Date Svc Ended**
Intensive Behavioral Health Services (IBHS) (formerly known as BHRS)	☐	Current	☐	Prior		
Casemanagement / Support Coordination	☐	Current	☐	Prior		
Community Residential Rehabilitation (CRR)	☐	Current	☐	Prior		
Drug & Alcohol Outpatient	☐	Current	☐	Prior		
Family Based MH Services	☐	Current	☐	Prior		
Inpatient Hospitalization	☐	Current	☐	Prior		
Multi-Systemic Therapy (MST)	☐	Current	☐	Prior		
Mental Health Outpatient (Clinic or School-based)	☐	Current	☐	Prior		
Partial Hospitalization	☐	Current	☐	Prior		
Residential Treatment	☐	Current	☐	Prior		
Student Assistance Program (SAP)	☐	Current	☐	Prior		

Please identify agencies/person(s) you feel should participate in CASSP meeting.		
Contact Name	**Address**	**Phone #**

Additional Comments

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

FOR OFFICE USE ONLY – CASSP MEETING INFORMATION
Date: _____ **Time:** _____ **Location:** _____

Revised April 27, 2020

Referral Source Signatures

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

Signature of Referral Source	Date
Signature of Mother/Guardian	Date
Signature of Father/Guardian	Date
Signature of the Child (if over 14 years of age)	Date

Authorization to Release Information

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

Youth	Date
Mother/Guardian	Date
Father/Guardian	Date
Witness	Date

Please send completed form to

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

Or

dadeyr@westmoreland.swsix.com

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

Revised April 27, 2020