



SERVICE COORDINATION MECHANISM

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Overview of Service Coordination

Purpose

The purpose of Service Coordination and High-Fidelity Wraparound through Huron County Family and Children First is to provide a neutral venue for families requiring services where their needs may not have been adequately addressed in traditional agency systems. Service Coordination is a process of service planning and system collaboration that provides individualized services and supports to families who have needs across multiple systems. It is child-centered and family-focused, with the strengths and needs of the child and family guiding the types and mix of services to be provided. It is critical that services and supports are responsive to the cultural, racial, and ethnic characteristics of the community population. Based on the level of severity or need, service coordination in Huron County can be elevated to the more intense High-Fidelity Wraparound process for those children and families who are at very high risk of experiencing poor outcomes.

A System of Care is a coordinated network of community-based services and supports that are organized to meet the challenges of children and youth with multiple needs and their families. Service Coordination and High-Fidelity Wraparound are collaborative, coordinated, cross-system team-based planning processes implemented to address the needs of youth and families where those needs are multiple and complex. Service Coordination and High-Fidelity Wraparound build upon the strength of services in the community, and when needed, propose new services, supports, and/or strategies to be added in order to address unmet needs. A System of Care must account for:

- Broad array of services & supports available
- Individualized Family Plan
- Least restrictive setting
- Coordinated at both system & service level
- Family-driven, youth-guided
- Emphasize early identification & early intervention

Values

The success of Service Coordination efforts depends on integrating key values into the process. The following list of values are integral to the effective delivery of Service Coordination and Wraparound:

- Services are delivered using a family-centered approach
- Services are responsive to the cultural, racial, and ethnic characteristics of the families being served.
- Service outcomes are evaluated.
- Available funding resources are fully utilized or integrated.
- Home and community supports are utilized as needed.
- Specialized treatment for difficult-to-serve populations and evidence-based treatment services are encouraged
- Duplicative or competing efforts among agencies are reduced or eliminated.
- Families deserve the shortest step from hello to help.
- Most importantly, families and youth are fully involved in decision-making and are provided with family advocacy and support options, if available.

Continuum of Care

A Continuum of Care is a method for tracking and guiding youth and families with multi-system needs over time through a comprehensive array of services spanning all levels and intensity of care. Huron County provides a Continuum of Care for ages 0 through 21 through the provision of various levels of coordination including: Information and Referral, Early Intervention Service Coordination, Service Coordination, and High-Fidelity Wraparound. The criteria for the appropriateness of each level of coordination is as follows:

- **Information and Referral**- Provided to any family with a child ages 0-21 whose only presented need is to be connected to another community resource or support. Referrals can be self-referrals or initiated by a youth serving agency.
- **Early Intervention Service Coordination**- Provided to any family with a child ages 0-3 who qualifies for early intervention services based on a developmental delay or diagnosis (run through the Huron County Board of Developmental Disabilities) based on a need for service.
- **Service Coordination**- Provided to any family with a child ages 0-21 who needs services and supports from more than one agency and is not already receiving Service Coordination through Early Intervention.
- **High-Fidelity Wraparound** - Provided to any family with a child ages 0-21 who has multiple and complex needs that cannot be met by traditional agency services and supports.

Based on the needs of the youth and family, a higher level of assistance may be needed to adequately address the presenting needs. Through coordination, Huron County Family and Children First Council can access various levels of intervention including the following, in order of least intensive to most intensive:

- Respite
- Mental Health Counseling
- Peer Recovery Support
- Recovery Care Coordination (following completion of a Recovery Program)
- Crisis Response via 24 -hour hotline
- Intensive Home-Based Treatment
- Residential Placement

When accessing the intervention services, the chosen coordination process shall continue throughout in order to ensure that the youth and family have the proper level of service and supports. **High-Fidelity Wraparound** will be implemented for a minimum of 6 months following the discharge of a youth from residential placement.

Mechanism Function and Structures

Service Coordination

Early Intervention Service Coordination is available for families with children ages 0 to 3 who have been diagnosed with a developmental disability or delay. An Early Intervention Service Coordinator meets with families to gather information and conduct a family needs assessment. They also coordinate a developmental evaluation, and coordinate services, if needed. The Family and Children First Council will assist with a family's Early Intervention Plan where needed but the process is headed up by Huron County Early Intervention: <https://www.hurondd.org/early-intervention.html>, contact Carol Robinson, Coordinator @ (419) 668-4769.

Service Coordination is a broad-based, youth and family-driven planning process by which previously identified resources and supports are coordinated to determine the least restrictive plan of success for youth with complex needs. Service Coordination can include teams composed of representatives from various systems that may be involved with the child/family/youth as well as other significant persons in the lives of the families. The Service Coordination process functions to:

- Problem solve at system-level
- Plan and monitor for family and child/youth safety
- Monitor placements (MSY funding)
- Manage risk and complex decisions concerning level of care
- Neutrally positioned facilitation and planning process
- Coordinate previously identified and existing resources and supports

High-Fidelity Wraparound is a specific evidence-based planning and facilitation process that builds a team around a child/youth and their family, including representatives from various systems that may be involved with the child/youth/family, service providers, relatives, neighbors, or other significant persons in the lives of the family. This organizing process individualizes services and supports, both formal and informal, around the strengths and needs of the child/youth/family to achieve improved and more meaningful outcomes. The intensity of this level of care coordination best serves children and youth who are at high risk of experiencing poor outcomes. High-Fidelity Wraparound consists of distinct steps or phases that must be followed:

- Phase 1: Engagement and team preparation
- Phase 2: Initial plan development
- Phase 3: Implementation
- Phase 4: Transition/Graduation

Intersystem Placements

Although it is a priority of the Service Coordination Mechanism to find the least restrictive intervention for children/youth, there may be times when out-of-home placement may be a necessary option.

Service Coordination Management Team

The Service Coordination Management Team serves as a community team and is to be comprised of representatives from Children Services, Job and Family Services, Juvenile Court, the Board of Developmental Disabilities including Early Intervention, FCFC Director, family representatives, and Mental Health Agencies including but not limited to Firelands Counseling & Recovery Services and Family Life Counseling.

Each appointed member of the Service Coordination Management Team is expected to regularly attend and participate. The team will meet at least monthly with meetings lasting up to three hours. If there are any assignments or information to review prior to the meeting, each team member is expected to come prepared. In addition, each team member may have opportunities to participate in trainings related to Service Coordination, Wraparound and Cross-System Planning. The responsibilities of the Service Coordination Management Team include:

- the review of requirements for entry to the Wraparound and Service Coordination programs
- accesses flexible funding in order to provide tailor-made and creative supports and services to individual families involved in Wraparound and Service Coordination.
- track outcomes across families to identify trends which can be used to inform funding decisions and program development
- make recommendations to the FCFC Executive Committee or Council for program development, modifications or expansion
- provide consultation as requested by Wraparound facilitators and Service Coordinators on issues related to system barriers
- monitor intersystem placements
- assure that there is “no wrong door” for families. When families contact an agency who cannot provide services, the agency facilitates a referral with the necessary follow-up to ensure that families receive a “warm hand-off” to an agency who can meet the family’s needs.

Operations and Procedures

Referrals

Referrals for Service Coordination and Wraparound can be made by calling the Director of Family and Children First, (419) 668-8126 ext. 3336 or by emailing or faxing a completed Service Coordination/Wraparound Referral Form to Family and Children First (see Addendum A- Referral Form). An initial assessment of the family's level of need will be made through an intake appointment with the family. A family will be contacted within 72 hours of referral and an intake appointment scheduled within 5 active business days of the referral. Referrals for Early Intervention Service Coordination (for ages 0-3 with a developmental delay or diagnosis) can be made through Huron County Early Intervention, Carol Robinson, Coordinator (419) 663-4769.

Educating Families & Agencies

Agency personnel and community members will become aware of the Service Coordination Mechanism of Huron County through the distribution of information to all member agencies of Council. Trainings on the Service Coordination Mechanism will be held annually to service providers by a HCFCFC staff member. Social media and community presentations will be utilized by the FCFC to strengthen outreach efforts related to the Service Coordination Mechanism.

Confidentiality

All Family & Children First Council participants have entered into a confidentiality agreement which assures the timely access to appropriate information while respecting the right to privacy of children and parents. All families involved in Service Coordination/Wraparound, Family Team Meetings And Early Intervention sign a Release of Information form initiated prior to formation of the Family Team or the sharing of family/agency information. The Family & Children First Release for Information will be signed by the parents for a period not to exceed 180 days. Parents are informed of their right to revoke the release in writing at any time. The Release of Information shall follow the ODH guidelines as applicable. At the first official team meeting, an agreement of confidentiality is also signed by all the team participants.

Eligibility

In order for a child, youth, or young adult to be eligible for Service Coordination in Huron County, they must meet each of the four eligibility criteria:

- Huron County resident
- Multi-systemic issues (i.e., involved with mental health, juvenile court, IEP, DD, etc.)- While the child/youth/young adult may not yet be involved in multiple systems, they have multiple needs that threaten to destabilize the family or put them at risk for homelessness or loss of employment.
- Child/youth is between the ages of 0 and 21 (or based on restrictions of available funding)
- Demonstrate significant needs based on assessment
- If funding allows, Service Coordination supports can assist adults, over the age of 21 with social, emotional, and daily living needs including employment.

If referred for Wraparound, at least one of the following additional criteria must be met:

- Does not have an existing Service Coordination process in place and is at high-risk of experiencing poor outcomes as demonstrated through significant needs in three or more areas of CANS and/or designated assessment
- Service Coordination process is in place but is in need of an alternative process due to system barriers or lack of care alternatives.

- Service Coordination process is in place, but family is not satisfied with existing process and seeks alternative coordination process

High-Fidelity Wraparound

Phase 1: Engagement and Team Preparation

During this phase, the groundwork for trust and shared vision among the family and Wraparound team members is established. In face-to-face conversations, the facilitator explains the Wraparound process and philosophy to the family members with the goal of helping the family and youth to make an informed choice regarding participation in the Wraparound process. The facilitator reviews all consent and release forms with the family and informs them of their rights. The facilitator will also ask the family about immediate crisis concerns and work with the family and agency representatives to address these concerns immediately, when present. The facilitator will spend time getting to know the strengths, needs, culture, and vision of the child/youth and family. From these conversations, a narrative is developed and is later shared in the first Team Meeting so that all team members have a clear understanding of the family's perspective, culture, strengths and needs. The narrative will form the basis for the Individual Family Service Plan (IFSP).

Each family engaged in

Wraparound will be given the opportunity to design their own family team. All families will sign a Release of Information prior to contacting potential team members (See Addendum B). To form a Team, families will be encouraged to invite informal (natural) supports such as family members, friends, church members, and neighbors. Formal supports that families could invite to their team could include: case workers; counselors; teachers and other school representatives; Job and Family Services staff; Juvenile Court staff; SSAs or other County Board of DD staff; and coaches. Families are also encouraged to invite advocates, mentors, and peer supporters to participate in family team meetings.

All service providers and those individuals serving as natural supports for families in the Service Coordination/Wraparound process will be notified of individual family service plan meetings thru email unless a preference is stated otherwise. The family will have the opportunity to meet and engage with their assigned Facilitator during the intake process.

The Child and Adolescent Needs and Strengths (CANS) Assessment tool will be used to categorize a youth/family's level of need based on measurements in a variety of life domains. The CANS will also be used to identify priority areas of need that will be used in the development of the Individualized Family Service Plan (IFSP). A reassessment will be administered at least every ninety (90) days to each youth/family involved in Service Coordination/High Fidelity Wraparound to measure progress.

The Wraparound Facilitator will record all team member contact information and compile a team roster for the family. The Wraparound Facilitator or Team Support Staff will contact all team members prior to a scheduled team meeting by email unless another method of communication is preferred by a team member. Team members will also be informed of the next-scheduled meeting date prior to leaving each Family Team meeting. In addition, team meetings are scheduled at times and locations that are convenient to the family.

Phase 2: Initial Family Service Plan Development

This phase begins with the team developing their mission, which guides the process for the family. Team trust and mutual respect are built while the team creates an initial Wraparound plan of care reflective of the Wraparound principles. Family culture, strengths, and needs across the domains that the child/youth and parent/guardian(s) have identified in the CANS assessment are the foundation for this plan. In this stage, usually lasting 1-2 meetings, the following work is completed by the team:

- Needs are prioritized
- Measurable goals are developed
- Strategies to meet goals are identified
- Clearly defined tasks and timelines are developed to accomplish strategies
- Responsibilities are assigned to team members

The Wraparound approach is focused on implementing a family plan in the least restrictive setting and appropriate level of service intensity. If needed services or supports are not available, the Family Plan will outline efforts to address such gaps.

During the development of the family plan, shall acknowledge that family crisis and safety issues are a possibility, and shall develop a plan for navigating a short-term crisis or safety concern. A crisis response plan, detailing options for preventing a known crisis and responses by those supporting the youth and family through such an event, should be developed based on family need and preference. Any safety concerns or safety programming should be addressed as needed.

Phase 3: Plan implementation

During this phase, the initial Wraparound Plan is implemented. Progress, satisfaction, and successes are continually reviewed at families' Team Meetings. Changes are made to the plan as needed while continuously striving to build and/or maintain team cohesiveness and mutual respect. If multiple plans are required to operate simultaneously due to system mandates, these plans are coordinated to eliminate duplication and conflicting expectations, with minimal overlap and duplication. Team members are assigned tasks that relate to the accomplishment of each established strategy. Progress is tracked by the facilitator at each team meeting and new action steps and strategies are considered where necessary. The facilitator updates the plan and distributes minutes of each meeting. The activities of this phase are repeated until the team's mission is achieved and formal Wraparound is no longer needed. This phase typically lasts 6-18 months.

Throughout the implementation phase, outcomes will be measured at least every 90 days through the Child and Adolescent Needs and Strengths (CANS) Assessment or designated assessment. Wraparound fidelity and family satisfaction will be measured at least every three meetings through the Wraparound Fidelity Index Assessment. Outcome measures and other data will be stored on the Fidelity Electronic Health Records System.

Phase 4: Transition

During this final phase, plans are made for a purposeful transition out of formal Wraparound and to a mix of formal and natural supports in the community, or, if appropriate, to services and supports in the adult system. The focus on transition is continual in the Wraparound process and the preparation for transition is apparent even in the initial engagement activities. A post-transition crisis- management plan is developed that capitalizes on the youth and family's now strengthened skills and knowledge. A commencement ceremony is created, which is culturally appropriate and meaningful to the family and youth. Once transition is complete, Wraparound staff continue to check in with the family to ensure that the family is continuing to experience success.

Families Right to Request Team Meeting

All families will be provided with a Team Communication List prior to the second team meeting. Families are invited to schedule team meetings through their own initiative or allow the Facilitator to schedule meetings according to the family's directive. It is expected that notice of future meetings will be given via email (or preferred contact if otherwise mentioned) at least one week (7 days) in advance except in cases of emergency. When deciding the time and location of meetings, the family's needs and limitations should be carefully considered.

Out-of-Home Placements

While Wraparound is focused on serving children/youth in the community and promoting least restrictive settings, there may be times when a child/youth in Wraparound becomes at-risk of out-of-home placement. This may be the result of an ongoing development or an acute crisis situation.

- Non-emergency: The Wraparound Facilitator will convene the Wraparound team to ensure that other options to placement are fully explored and/or exhausted prior to placement.
- Emergency: The Wraparound Facilitator will convene the team within 10 days of an emergency out-of-home placement to plan for the return of the child/youth to the community or determine next steps.

Alleged Unruly Child and Diversion from Juvenile Court

With the formation of a family team and the formulation of an Individualized Family Service Plan, a youth, if identified prior to unruly or delinquent charges being filed, should successfully be diverted from Juvenile Court involvement. If the preparation of a complaint under section 2151.022- (Unruly Child) of the Ohio Revised Code has been filed, the youth and parents of the youth will be encouraged to become involved in the Wraparound process to divert the youth from Juvenile Court.

Disengagement Exit Policy

In times where it has been determined between the Service Coordinator/Wraparound Facilitator and Director that a family has disengaged, i.e. stopped returning correspondence, cancels or does not show up to meetings, etc. The coordinator/facilitator must follow the following steps before officially closing a family out of the program.

1. Three attempts must be made to contact the family. These attempts should be of various types of communication (i.e. text, email, phone) and on varying days/times. Ensure documentation of contact. If return correspondence is not received within three days of contact attempts, move on to step two.
2. Coordinator/Facilitator should reach out to the family team to inquire about alternate ways to contact family or to see if members would be willing/able to contact family. In the case that a family team has not yet been created, Coordinator/Facilitator should reach out to referral source for the same requests. If additional contact methods are identified coordinator/facilitator should follow contact rules in step one and wait three days for return correspondence. Ensure documentation for all contact attempts and correspondence with team members. If return correspondence is not received within three days, move on to step 3.
3. Send out Family Disengagement Letter (attached) to the last known address of the family. Keep a copy of the letter in the family's file. The staff member will notify the FCFC Director and disengage the family from the program.

A family may choose to refer to or be referred by an agency in the future but may be subject to wait list if Service Coordinator/ Wraparound Facilitator caseloads are at capacity.

Dispute Resolution Process

The purpose of service coordination is to provide a venue for families needing services where their needs may not have been adequately addressed in traditional agency systems. Each agency system has areas of responsibility and the collaborative approach is not intended to replace or usurp the primary role of any one of these systems. Dispute resolution is an important component of any services delivery system. Although agencies and professionals are committed to meeting the needs of the child and/or family there are times when one or more members of the team may question decisions or the process. In all instances, families are encouraged to ask questions and become informed as to what is available, what their child might need, and what rights and responsibilities they have as parents. Conflicts may arise in three distinct types of situations:

- One agency is in disagreement with other agencies about a Family Service Plan;
- The family is in disagreement with one agency; or
- The family is in disagreement with the service plan.

If the dispute does not pertain to service coordination, parents or custodians shall use existing local agency grievance procedures to address disputes. This process is in addition to and does not replace other rights or procedures that parents or custodians may have under other sections of the Ohio Revised Code. Each agency represented on a county Family and Children First Council (FCFC) that is providing services or funding for services that are the subject of the dispute initiated by a parent shall continue to provide those services and the funding for those services during the dispute process. These rights shall not be interpreted as overriding or affecting decisions of a juvenile court regarding an out-of-home placement, long-term placement, or emergency out-of-home placement.

The FCF Council shall inform parents and/or custodians of their rights to use the dispute resolution process. Parents or custodian shall use existing local agency grievance procedures to address disputes not involving Service Coordination.

Disputes between Agencies

When an agreement cannot be reached by the systems involved in a Wraparound Team regarding family assessment, service plan development, the assignment of responsibilities to implement the service plan, or difficulties in the implementation of the plan, either the parent(s) or the service provider(s) may petition the Executive Committee of the Huron County Family and Children First Council to review their concerns. The Executive Committee will, in a timely manner, arrive at an agreed upon solution by all parties involved. Under the provisions of this plan, at no time during the dispute resolution process shall services to the youth/child, parent(s) and family be disrupted. Families, upon accessing services, will be advised of their legal rights beyond the dispute resolution process.

Family Team Disputes

The process for handling each of the above situations is dependent on the premise that individuals and agencies will, in all instances, seek clarification and resolution at the Family Team level prior to initiating the formal conflict resolution process. The Family Team serves to utilize the recommendation of all parties, including that of the parent or guardian, that promotes the well-being of the child(ren) in regards to services for the child(ren). If there is significant and unresolved conflict regarding any aspect of the Family Service Plan by any participant (including parents) in the Wraparound process, every attempt is made to

resolve that conflict with the participating members of the Family Team. If the Family Team cannot resolve the dispute, the dispute resolution process can be initiated. Each family will be notified of their right to utilize the dispute resolution process and provided information regarding the process at the first Family Team meeting. Parents who choose to utilize an advocate or mentor are encouraged to include those representatives in the process. If difficulties in resolution at this level occur, the Council Director can be asked to sit on the team as a mediator for conflict resolution. At no time during the dispute resolution process will services to the family be disrupted. This keeps the conflict mediation and dispute resolution as close to the direct level of care as possible.

Non-emergent disputes between Parent/Guardian and FCFC

A non-emergent dispute will be defined as a dispute that does not require an immediate response due to the safety or well-being of the child(ren). If a non-emergent dispute is initiated by a parent or guardian, the following timeline will be utilized:

1. Within seven calendar days of the disagreement/dispute, the family will submit a Dispute Resolution request to the FCF Director communicating the desire to utilize the dispute resolution process. Supporting evidence or documentation concerning the dispute should be submitted with this request. This request should be submitted to:

**Huron County Family and Children First Council
Attn: FCFC Director
185 Shady Lane Dr
Norwalk, Ohio 44857**

2. Upon receipt of the family request to utilize dispute resolution, a meeting with the Executive Committee will be convened within 15 calendar days. This meeting will be scheduled at a mutually convenient time for the majority members of the family and the Executive Committee. The family will prepare a presentation for the Executive Committee regarding the nature of the dispute and the specific issues that are requested to be resolved. This presentation can be made by the family, an advocate, or the lead case manager.

3. At the meeting with the Executive Committee, the family will present information regarding the nature of the dispute and identify specific issues that are requested to be resolved. All pertinent service coordination/wraparound case information will be completed by the Family Team and the family to provide historical and current information relevant to the dispute and to specifically identify the issues sought to be resolved. The Executive Committee will meet in a closed session after the family's presentation to draft written responses to the family regarding the issues identified in the dispute. The executive committee will either approve or reject the responses in writing. The family will receive response of the decision via certified mail within seven (7) calendar days of the dispute presentation. This response will address all disputes identified in the dispute resolution process.

4. When the provision of services cannot be resolved through the designated dispute resolution process, the case will be sent to the OCFC for recommendation and the final arbitrator will be the Huron County Family and Children First Council. When the provision of services cannot be resolved through the designated dispute process, the family must submit a request in writing within seven (7) calendar days of receipt of response to have the dispute to be decided upon by the final arbitrator. Upon receipt of this request, the Director for FCF will submit all the documentation, including but not limited to, the request for dispute resolution and supporting documentation, responses made by the Executive Committee, treatment information, and other relevant information to the regarding the dispute within five (5) calendar days to the OFCF for a recommendation on the case. The final arbitrator will be the HCFCFC. The FCFC coordinator will issue a response within 14 calendar days of the decision made by the HCFCFC. The entire process shall be completed in no more than 60 days.

Emergent Disputes between Parent/Guardian and FCFC

An emergent dispute will be defined as a dispute that requires an immediate response due to the safety or well-being for the child(ren). In these instances, the immediate decision is made collaboratively with the parents or guardians and an immediate staff available. FCF will work to address the emergency in the most timely and effective means possible. If an emergent dispute is initiated by a parent or guardian, the following timeline will be utilized:

1. Within three (3) calendar days of the disagreement/dispute, the family will submit a dispute resolution request to the FCF Director communicating the desire to utilize the dispute resolution process. Supporting evidence/documentation concerning the dispute should be submitted with this request. The request should be submitted to:

Huron County Family and Children First Council
Attn: FCFC Director
185 Shady Lane Dr
Norwalk, Ohio 44857

2. Upon receipt of the family request to utilize dispute resolution, a meeting with the Executive Committee will be convened within 5 calendar days. This meeting will be scheduled at a mutually convenient time for the majority members of the family and the Executive Committee. The family will prepare a presentation for the Executive Committee regarding the nature of the dispute and the specific issues that are requested to be resolved. This presentation can be made by the family, an advocate, or the lead case manager.

3. At the meeting with the Executive Committee, the family will present information regarding the nature of the dispute and identify specific issues that are requested to be resolved. All pertinent service coordination/wraparound case information will be completed by the Family Team and the family to provide historical and current information relevant to the dispute and to specifically identify the issues sought to be resolved. The Executive Committee will meet in a closed session after the family's presentation to draft written responses to the family regarding the issues identified in the dispute. The Executive Committee will either approve or reject the responses in writing. The family will receive response of the decision via certified mail within three (3) calendar days of the dispute presentation. This response will address all disputes identified in the dispute resolution process.

4. When the provision of services cannot be resolved through the designated dispute resolution process, the case will be sent to the OFCFC for recommendation and the final arbitrator will be the Huron County Family and Children First Council. When the provision of services cannot be resolved through the designated dispute process, the family must submit a request in writing within seven (7) calendar days of receipt of response to have the dispute to be decided upon by the final arbitrator. Upon receipt of this request, the Director for FCF will submit all the documentation, including but not limited to, the request for dispute resolution and supporting documentation, responses made by the Executive Committee, treatment information, and other relevant information to the regarding the dispute within two (2) calendar days to the OFCF for a recommendation on the case. The final arbitrator will be the HCFCFC. The FCFC Director will issue a response within 10 calendar days of the decision made by the HCFCFC. The entire process shall be completed in no more than 30 days.

5.

Quality Assurance, Data Management, and Evaluation

As part of the overall monitoring and evaluation of all aspects of the Service Coordination Mechanism, there are three primary areas of focus:

- Pre and Post Evaluative Tools- we will utilize the Protective Factors Survey in Service Coordination to measure the following: Family Functioning/Resiliency; Social Emotional

Support; Concrete Support; Nurturing & Attachment; and Child Development/Knowledge of Parenting. We will use the Child and Adolescent Needs and Strengths Assessment (CANS) for youth involved in Wraparound services.

- Quality (Fidelity) and Satisfaction-The Wraparound Fidelity Index will be administered with each Wraparound Team. It is a self-administered survey that measures adherence to the Wraparound principles. Respondents (caregivers, youth, facilitators, and team members) answer questions in three categories: Experiences in Wraparound, Satisfaction, and Outcomes.
- Outcomes- In addition to the Wraparound Fidelity Index, the Child and Adolescent Needs and Strengths (CANS) Assessment will be used to measure outcomes in Wraparound cases. The CANS measures needs and strengths across life domains and will be administered at intake and at least once every 90 days to measure progress.
- Costs- In order to monitor the overall cost-effectiveness of the Service Coordination Mechanism, costs will be tracked against quality, satisfaction, and outcomes for each Wraparound team.

The data will inform the SCMT actions to: stop funding ineffective services and supports, recommend alternative services and supports be sought out, or seek more information to inform their decision-making. The Service Coordination Mechanism will be reviewed by the Service Coordination Management Team annually to ensure that it is being kept up to date, is effective and reflects the process that is being practiced by the county.

Funding

In order to fund the core functions of Intersystem Care Coordination, Huron County will utilize Family Centered Services and Supports (OMHAS) funding. In addition, local pooled or Multi-System Youth funding will be utilized for intersystem placements as well as supports for intersystem children/youth designed to help avoid out-of-home placements. In an effort to adequately and appropriately manage flexible fund spending, the Service Coordination Management Team will use the following criteria in its oversight:

Does the intervention, planned interaction, or expenditure:

- Build on family strengths?
- Add value to the stated family mission?
- Meet identified child and family needs?
- Represent a culturally competent direction?
- Build on community capacities?
- Represent a good deal for the investment?

When a service or support is deemed appropriate, specifications (fund restrictions/allowances) will be carefully considered before choosing the fund source. All efforts will be made to spend from the most flexible funding sources only when funding is needed for services and supports that could not be funded through other means.

APPENDIX A: Referral Form

APPENDIX B: Release of Information

APPENDIX C: Protective Factors Survey

APPENDIX D: CANS Assessment

APPENDIX E: Family Disengagement Policy

APPENDIX F: Disengagement Letter

APPENDIX A

REFERRAL FORM

Date: _____



Referral

by: _____ Agency/Organization: _____

Phone: _____ Email: _____

Youth's Name:	Date of Birth:	Race:	Gender/Identificat ion:

Reason for Referral: (check all that apply)

<input type="checkbox"/> Developmental Disability	<input type="checkbox"/> Substance/Alcohol Abuse	<input type="checkbox"/> Early Intervention
<input type="checkbox"/> Child Neglect	<input type="checkbox"/> Poverty	<input type="checkbox"/> Delinquent
<input type="checkbox"/> Medical	<input type="checkbox"/> Behavior Problems	<input type="checkbox"/> Abandonment
<input type="checkbox"/> Family Conflict	<input type="checkbox"/> Legal Issues/Incarceration	<input type="checkbox"/> Physical Abuse
<input type="checkbox"/> Poor Social Skills	<input type="checkbox"/> Suicidal Ideation	<input type="checkbox"/> Mental Health
<input type="checkbox"/> Special Education	<input type="checkbox"/> Child Abuse	<input type="checkbox"/> Physical Health Concerns
<input type="checkbox"/> Autism Spectrum Disorder	<input type="checkbox"/> Aggression/Assault	<input type="checkbox"/> Death of parent/guardian
<input type="checkbox"/> Stealing	<input type="checkbox"/> Runaway	<input type="checkbox"/> Sexual Abuse
<input type="checkbox"/> Cruelty to Animals	<input type="checkbox"/> Problem Sexual Behavior	<input type="checkbox"/> Hyperactivity
<input type="checkbox"/> Sleep disturbance	<input type="checkbox"/> Destruction of Property	<input type="checkbox"/> Experienced Developmental Trauma

Custody: ____ Adopted Parent(s) ____ Biological Parent(s) ____ Legal Custody of Family Member

____ Children Services ____ Temporary Custody of Family Member

No

If yes complete the following:

Placement:	Contact:
Address:	Phone:
City: Zip: State:	Email:

Is the child currently at-risk for out-of-home placement?

Yes

No

If yes, please explain:

SUPPORTS:

PROFESSIONAL SUPPORTS	Contact Info-Name, Phone # Agency Name	Email Address
Name of Contact		
Children Services		
Juvenile Court		
Mental Health Provider		
Substance Abuse Treatment Provider		
Huron County Department of Developmental Disabilities		
Department of Youth Services		
School		
NATURAL SUPPORTS (family, mentors, close friends, etc.)		

Name of Contact: (if known):	Relationship:	Phone:	Email Address

Additional Information

1. Is the Youth/Child currently enrolled in school?

- Yes Name of School: _____ Homeschooled: _____
 No

2. Does the Youth/Child have an IEP?

- Yes
 No Grade Level _____

3. Does the Youth/Child have a Mental Health Diagnosis?

- Yes Date of Diagnosis: _____ Diagnosed By: _____
 No

MENTAL HEALTH DIAGNOSIS:

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Mood D/O	<input type="checkbox"/> PTSD	<input type="checkbox"/> Disruptive Mood Dysregulation D/O
<input type="checkbox"/> Depression	<input type="checkbox"/> Conduct D/O	<input type="checkbox"/> Psychosis	<input type="checkbox"/> Other (list below):
<input type="checkbox"/> Attachment D/O	<input type="checkbox"/> Oppositional Defiant D/O	<input type="checkbox"/> Schizophrenia	
<input type="checkbox"/> Bipolar D/O	<input type="checkbox"/> Obsessive Compulsive D/O	<input type="checkbox"/> Eating D/O	

DD DIAGNOSIS:

<input type="checkbox"/> Severity Unknown	<input type="checkbox"/> Mild (IQ 55-69)	<input type="checkbox"/> Moderate (IQ 41-55)	<input type="checkbox"/> Severe (IQ 27-41)
---	--	--	--

<input type="checkbox"/> Autism Spectrum	<input type="checkbox"/> Other Developmental Disability		
DX: (Please list)			

4. Is an assessment scheduled?

- Yes When: _____ Where: _____
 No

5. Does the Youth/Child have pending charges in Juvenile Court?

- Yes
 No

6. Are there currently safety concerns for the youth or family members?

- Yes
 No

If so, please explain:

7. What is the intended service, as recommended by the referring agency?

- Service Coordination (youth-focused, individually based)
 High Fidelity Wraparound (family-focused, more intensive cases)

IN WHAT WAYS WOULD FCFC SERVICE COORDINATION BENEFIT THIS FAMILY?

WHAT ARE THE STRENGTHS OF THIS FAMILY?

8. Have there been other interventions/providers involved other than those listed above? If yes, please

list/explain: _____

9. **PLACEMENT HISTORY: Please attach documentation related to placement history, when & where (hospitalizations, residential, foster care, DYS, DH).**

***A referral will not be accepted without a completed Release of Information signed by the legal guardian of the youth being referred.**



Send completed forms to:

Family and Children First Council of Huron County

Attn: Niki Cross, Director

Nicole.Cross@jfs.ohio.gov

185 Shady Lane Drive

Norwalk, OH 44857

(419) 668-8126 ext. 3336 FAX: (419) 668-4738

APPENDIX B

HURON COUNTY FAMILY & CHILDREN FIRST COUNCIL CLIENT AUTHORIZATION FOR INFORMATION SHARING

I hereby authorize the Member agencies of the Huron County Family & Children First Council, named on the reverse side of this Authorization, to exchange, give, receive, share, or redisclose information in their records, from whatever source derived, related to my participation and that of my minor child:

Name of Child: _____ Date of Birth: _____ in the services provided by one or more of these agencies.

I understand the following:

1. The purpose of this information sharing is to improve the communication about services to me and my family.
2. Each of the member agencies has agreed:
 - a) to share this information only with other member agencies;
 - b) not to share information with non-member agencies without my written consent unless otherwise required or authorized by law; and
 - c) Information exchanged due to this authorization will not be used against me or my children for purposes of criminal investigation, prosecution, or sentencing, unless otherwise required by law or judicial order.
3. Any and all rights to confidentiality, which I may have under state or federal law, will continue, except for information covered by this form
4. I may revoke this Authorization at any time except for information that has been previously exchanged.
5. This Authorization shall automatically expire 180 days from the date below unless I revoke it sooner.
6. This Authorization shall not restrict information sharing otherwise authorized by law.

I authorize sharing of the following information: (Circle and initial, if yes, and sign below)

Yes _____ **Case Information:** Identifying information, plus medical and social history, treatment/service history, Psychological evaluations, IEP's, IFSP's, transition plans, vocational assessments, grades and attendance, financial information and other personal information held by any of the member agencies regarding me or my minor children.

Yes _____ Mental health diagnosis and treatment

If yes: This Authorization for information sharing has been explained to me. I have read the disclosures below. I have been given a reasonable amount of time to ask questions and consider whether to permit sharing of this information. I hereby willingly agree to the sharing of information as described above.

Signature of Client

Date Signed

Signature of parent/guardian (if applicable)

Staff Person Facilitating this Authorization

Relationship of Person Signing to Client

I am also authorizing the exchange of information with the following specific persons/agencies:

Signature of Client (or parent/guardian if applicable)

Date Signed

05/20

MEMBER AGENCIES: (PLEASE CHECK EACH FOR AUTHORIZATION)

- Family & Children First Council Director/Council
- Regional/Local Family Advocates
- _____ City Schools
- Fidelity EHR
- Huron County Board of DD
- Mental Health & Recovery Services Board
- Huron County Department of Job & Family Services
- Huron County Family/Juvenile Court
- Fisher-Titus Medical Center
- Firelands Counseling & Recovery Services
- Huron County Early Intervention Collaborative
- Huron County Public Health
- Huron County Help Me Grow
- Family Life Counseling
- Huron County Child & Adult Protective Services
- The Nord Center

Rectangular Snip

Definition of "Case Information":

If this release authorizes the disclosure of Case Information, consent to such disclosure may include the following types of information, if it is in files of the agency disclosing this information:

- a. Identifying information: names, birth dates, sex, race, address, telephone number, social security number, type of services being received and name of agency providing services to me or my minor children. Medical records, including but not limited to results of physical and mental examinations, diagnoses of physical and mental disorders, medication history, physical and mental health status and history, summary of treatment services received, summary of treatment plans and treatment needs.
- b. Psychological and medical testing, including but not limited to any IQ tests or other tests of cognitive or emotional or mental status, and any reports of physical tests such as X-rays, CT scans, diagnostic blood testing, and other test results.
- c. All records of services provided by the Huron County Child & Adult Protective Services except child abuse investigation reports.
- d. Juvenile court and detention records.
- e. School records: This information is subject to the Family Educational Rights and Privacy Act of 1974, 20 USC 1232g, and the Ohio Student Records Privacy Act RC 3319.321.

To all Agencies receiving information disclosed pursuant to this consent:

If the records released pursuant to this consent include records of any diagnosis or treatment of drug or alcohol abuse, the following statement applies:

This information has been disclosed to you from records protected by Federal confidentiality rules (42CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly pertained by the written consent of the person to whom it pertains or as otherwise permitted by 42 CRF 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.

If the records released include information of 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 diagnosis.

APPENDIX C

Protective Factors Survey

Name: _____ Date of Birth: _____

Gender (how do you identify): _____ Age: _____

Intake

1. **Data survey completed:** ___/___/_____

2. Has the participant had any involvement with Child Protective Services?

- Yes
- No
- Not sure

3. Date participant began program (complete for pretest) ___/___/_____

4. Date participant completed the program (complete at posttest) ___/___/_____

5. Type of Service: Identify the type of program that most accurately describes the services the participant is receiving. Check all that apply.

- | | |
|---|--|
| <input type="checkbox"/> Parent Education | <input type="checkbox"/> Planned and/or Crisis Respite |
| <input type="checkbox"/> Parent/Child Interaction | <input type="checkbox"/> Fatherhood Program |
| <input type="checkbox"/> Parent Support Group | <input type="checkbox"/> Homeless/Transitional Housing |
| <input type="checkbox"/> Advocacy (self, community) | <input type="checkbox"/> Resource and Referral |
| <input type="checkbox"/> Family Resource Center | <input type="checkbox"/> Adult Education (i.e. GED/Ed) |
| <input type="checkbox"/> Skill Building/Education for Children | <input type="checkbox"/> Job Skills Employment Prep |
| <input type="checkbox"/> Pre-Natal Class | <input type="checkbox"/> Family Literacy |
| <input type="checkbox"/> Marriage Strengthening/Prep | <input type="checkbox"/> Home Visiting |
| <input type="checkbox"/> Other (if you are using specific curriculum, please name here) | |

6. Race/Ethnicity. (Please choose ONE that best describes what you consider yourself to be).

- | | |
|---|--|
| <input type="checkbox"/> A. Native American or Alaskan Native | <input type="checkbox"/> B. Asian |
| <input type="checkbox"/> C. African American | <input type="checkbox"/> D. African Nationals/Caribbean Islanders |
| <input type="checkbox"/> E. Hispanic or Latino | <input type="checkbox"/> F. Middle Eastern |
| <input type="checkbox"/> G. Native Hawaiian/Pacific Islander | <input type="checkbox"/> H. White (Non-Hispanic/European American) |
| <input type="checkbox"/> I. Multi-racial | <input type="checkbox"/> J. Other: |

7. Marital Status:

- Married | Partnered | Single | Divorced | Widowed | Separated

8. Family Housing:

- Own Rent Homeless

- Temporary (shelter, temporary with friends or relatives).
- Shared housing with relatives or friends

9. Highest Level of Education

- Elementary or Junior High School
- Trade/Vocational School
- 4-Year College Degree (Bachelor's)
- Some High School
- Some College
- Master's Degree
- High School Diploma or GED
- 2-Year College Degree (Associate's)
- PhD or Other Advanced Degree

10. Which, if any, of the following do you currently receive? (Check all that apply)

- Food Stamps
- TANF
- Medicaid (State Health Insurance)
- Head Start/Early Head Start Services
- Earn Income Tax Credit
- None of The Above

11. Please tell us about the children living in your household.

- Child 1: M/F
- Relationship to child
- Birth parent
- Adoptive parent
- Grand/Great Grandparent
- Other
- DOB:
- Sibling
- Other relative
- Foster-parent
- Child 2: M/F
- Relationship to child
- Birth parent
- Adoptive parent
- Grand/Great Grandparent
- Other
- DOB:
- Sibling
- Other relative
- Foster-parent
- Child 3: M/F
- Relationship to child
- Birth parent
- Adoptive parent
- Grand/Great Grandparent
- Other
- DOB:
- Sibling
- Other relative
- Foster-parent

12. Education

School Attended:	
Grade:	
Behaviors at school:	

13. Juvenile Court Involvement

On Probation: YES/NO	Does the child understand the conditions of Probation: YES/NO

Probation Officer:	
Pending Hearing: YES/NO Date:	What are the charges:
Current Custody:	

14. Past Services Used

Counseling	Medication	Diagnosis	Provider

Chemical Dependency	Prior Placement (list names of relatives)

15. Strengths of the Family

16. Concerns of the Family.

Youth Assessment

Part I – Please *circle* the number that describes how often the statements are true for you or your family. The numbers represent a scale from 1 to 5 where each of the numbers represent a different amount of time. The number 4 means that the statement is true about half the time.

	Never	Rarely	About Half the Time	Frequently	Always
In my family, we talk out problem.	1	2	3	4	5
When we argue, my family listens to “both sides of the story.”	1	2	3	4	5
In my family, we take time listen to each other.	1	2	3	4	5
My family pulls together when things are stressful.	1	2	3	4	5
My family is able to solve problem.	1	2	3	4	5

Part II – Please *circle* the number that best describes how much you agree or disagree with the statement.

	Strongly Disagree	Mostly Disagree	Neutral	Mostly Agree	Strongly Agree
I have others who will listen when I need to talk about my problems.	1	2	3	4	5
When I am lonely, there are several people I can talk to.	1	2	3	4	5
I would have no idea where to turn if my family needed food or clothing.	1	2	3	4	5
I wouldn’t know where to go for help if I had trouble making ends meet.	1	2	3	4	5
If there is a crisis, I have other I can talk to.	1	2	3	4	5
If I needed a help finding a job, I wouldn’t know where to go for help.	1	2	3	4	5

Parental/Guardian Assessment

Part III – This part of the survey asks about parenting and your relationship with your child. For this section, please focus on the child that you hope will benefit from your participation in our services. Please write the child’s age or date of birth and then answer questions with this child in mind.

	Strongly Disagree	Mostly Disagree	Neutral	Mostly Agree	Strongly Agree
There are many times when I don’t know what to do as a parent.	1	2	3	4	5
I know how to help my child learn.	1	2	3	4	5
My child misbehaves just to upset me.	1	2	3	4	5

Part IV – Please tell us how often each of the following happens in your family.

	Never	Rarely	About Half the Time	Frequently	Always
I praise my child when he/she behaves well.	1	2	3	4	5
When I discipline my child, I lose control.	1	2	3	4	5
I am happy being with my child.	1	2	3	4	5
I am able to soothe my child when she/he is upset.	1	2	3	4	5
My child and I are very close to each other.	1	2	3	4	5
I spend time with my child doing what he/she likes to do.	1	2	3	4	5

APPENDIX D



OH Comprehensive Child and Adolescent Needs and Strengths • Rating Sheet

Date:

Type: Initial Scheduled Update Major Life Event Exit

Assessor ID: <input type="text"/>	Program: <input type="text"/>
Client Name: <input type="text"/>	Client ID: <input type="text"/> DOB: <input type="text"/>
Gender: <input type="text"/> Ethnicity: <input type="text"/>	Grade: <input type="text"/> Zip Code: <input type="text"/>

Please Check All that Apply:

- There is no possible community living arrangement for the youth that is willing and able to support the intensive community treatment (e.g., wraparound) for the youth given their current needs.
- Youth was unsuccessful in intensive community treatment.
- Youth is in custody of, or on parole with, the Department of Youth Services.

For the **Strengths**, use the following categories and action levels:

- 0 – Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/action plan
- 1 – Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength
- 2 – Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful.
- 3 – An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.

STRENGTHS DOMAIN (Ages 6+)

Items	N/A	0	1	2	3		0	1	2	3
Family Strengths		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Community Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpersonal		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Relationship Permanence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Optimism		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Resilience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Educational Setting	<input type="checkbox"/>	Resourcefulness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Vocational	<input type="checkbox"/>	Cultural Identity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Talents and Interests		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Natural Supports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spiritual/Religious		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Youth Involvement in Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please write a rationale for Centerpiece ('0') and Useful ('1') Strengths, as well as Strengths to Build ('2' or '3').

For the **Needs Domains**, use the following categories and action levels:

- 0 – No evidence of any needs; no need for action.
- 1 – Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.
- 2 – Action is required to ensure that the identified need is addressed; need is interfering with functioning.
- 3 – Need is dangerous or disabling; requires immediate and/or intensive action.

LIFE FUNCTIONING DOMAIN (Ages 6+)									
Items	0	1	2	3		0	1	2	3
Family Functioning	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Living Situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	School Attendance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	School Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developmental/Intellectual (A)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	School Achievement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Decision Making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical/Physical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Basic Activities of Daily Living	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. DEVELOPMENTAL NEEDS MODULE (To complete when the Developmental/Intellectual item is rated '1', '2' or '3'.)									
Cognitive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developmental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Please write a rationale for any item in the Life Functioning Domain and related modules rated actionable ('2' or '3').									

BEHAVIORAL/EMOTIONAL NEEDS DOMAIN (Ages 6+)									
Items	0	1	2	3		0	1	2	3
Psychosis (Thought Disorder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anger Control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impulsivity/Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance Use (C)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attention/Concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autism Spectrum (D)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attachment Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oppositional Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Behavioral Regressions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conduct (Antisocial Behavior)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Somatization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adjustment to Trauma (B)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
B. TRAUMATIC STRESS SYMPTOMS MODULE (To complete when the Adjustment to Trauma item is rated '1', '2' or '3'.)									
Emotional and/or Phys. Dysregulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Avoidance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intrusions / Re-experiencing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traumatic Grief & Separation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dissociation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperarousal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
C. SUBSTANCE USE DISORDER MODULE (To complete when the Substance Use item is rated '1', '2' or '3'.)									
Severity of Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recovery Support in Community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Duration of Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acute Intoxication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stage of Recovery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Withdrawal History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peer Influences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Withdrawal Risks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parental/CG Influences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Awareness of Relapse Triggers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Environmental Influences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

D. AUTISM SPECTRUM MODULE (To complete when the Autism Spectrum item is rated '1', '2' or '3'.)							
Regulatory: Body Ctrl/Emotional Ctrl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Restricted Interests	<input type="checkbox"/>	<input type="checkbox"/>
Repetitive Behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensory Responsiveness	<input type="checkbox"/>	<input type="checkbox"/>

Please write a rationale for any item in the Behavioral/Emotional Needs Domain and related modules rated actionable ('2' or '3').

RISK BEHAVIORS DOMAIN (Ages 6+)									
Items	0	1	2	3		0	1	2	3
Suicide Risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Runaway (G)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-Suicidal Self-Injurious Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intentional Misbehavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Self-Harm (Recklessness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fire Setting (H)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Danger to Others (E)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Victimization/Exploitation (I)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delinquent Behavior (F)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Problematic Behavior (J)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E. DANGEROUSNESS/VIOLENCE MODULE (To complete when the Danger to Others item is rated '1', '2' or '3'.)									
Items	0	1	2	3		0	1	2	3
Historical Risk Factors					Violent Thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Resiliency Factors				
Emotional/Behavioral Risks					Aware of Violence Potential	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frustration Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Response to Consequences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hostility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Commitment to Self-Control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paranoid Thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Treatment Involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Secondary Gains from Anger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

F. JUVENILE JUSTICE MODULE (To complete when the Delinquent Behavior item is rated '1', '2' or '3'.)									
Items	0	1	2	3		0	1	2	3
History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peer Influences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seriousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Parental Criminal Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Environmental Influences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Legal Compliance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

G. RUNAWAY MODULE (To complete when the Runaway item is rated '1', '2' or '3'.)									
Items	0	1	2	3		0	1	2	3
Frequency of Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Likelihood of Return on Own	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consistency of Destination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Involvement with Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safety of Destination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Realistic Expectations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Involvement in Illegal Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

H. FIRE SETTING MODULE (To complete when the Fire Setting item is rated '1', '2' or '3'.)									
Items	0	1	2	3		0	1	2	3
History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Community Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seriousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Response to Accusation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Remorse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of Accelerants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Likelihood of Future Fire Setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intention to Harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

I. COMMERCIAL SEXUALLY EXPLOITED MODULE (To complete when the Victimization/Exploitation item is rated '1', '2' or '3' for youth identified as sexually exploited.)									
Items	0	1	2	3		0	1	2	3
Duration of Exploitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exploitation of Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Age of Onset - Exploitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reproductive Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perception of Dangerousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arrests for Loitering/Solicitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knowledge of Exploitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exploitation History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trauma Bond	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

J. SEXUALLY PROBLEMATIC BEHAVIOR MODULE (To complete when the Sexually Problematic Behavior item is rated '1', '2' or '3'.)

Items	0	1	2	3		0	1	2	3
Hypersexuality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Reactive Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Risk Sexual Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Masturbation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

J1. SEXUALLY AGGRESSIVE BEHAVIOR MODULE (To complete when the Sexual Aggression item is rated '1', '2' or '3'.)

Items	0	1	2	3		0	1	2	3
Physical Force/Threat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type of Sex Act	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Response to Accusation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Age Differential	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Temporal Consistency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of Sexually Aggressive Behav.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please write a rationale for any item in the Risk Behavior Domain and related modules rated actionable ('2' or '3').

CULTURAL FACTORS DOMAIN (All Ages. For Children birth thru age 5, rate this section for the family.)

Items	0	1	2	3		0	1	2	3
Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cultural Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traditions and Cultural Rituals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cultural Diff. within the Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please write a rationale for any item in the Cultural Factors Domain rated actionable ('2' or '3').

For the **Potentially Traumatic/Adverse Childhood Experiences**, use the following categories and action levels:

No – No evidence of any trauma of this type.

Yes – Child/youth has had experience, or there is suspicion that the child/youth has experienced this type of trauma—one incident, multiple incidents, or chronic, on-going experiences.

POTENTIALLY TRAUMATIC/ADVERSE CHILDHOOD EXPERIENCES -- LIFETIME EXPOSURE (All Ages)

	No	Yes		No	Yes
Sexual Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Witness to Family Violence	<input type="checkbox"/>	<input type="checkbox"/>
Physical Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Witness to Community/School Violence	<input type="checkbox"/>	<input type="checkbox"/>
Neglect	<input type="checkbox"/>	<input type="checkbox"/>	War/Terrorism Affected	<input type="checkbox"/>	<input type="checkbox"/>
Emotional Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Witness /Victim of Criminal Activity	<input type="checkbox"/>	<input type="checkbox"/>
Medical Trauma	<input type="checkbox"/>	<input type="checkbox"/>	Parental Criminal Behavior	<input type="checkbox"/>	<input type="checkbox"/>
Natural or Manmade Disaster	<input type="checkbox"/>	<input type="checkbox"/>	Disrupt in Caregiving/Attachment Losses	<input type="checkbox"/>	<input type="checkbox"/>

Please write a rationale for any item rated 'YES'.

EARLY CHILDHOOD DOMAIN (Age birth thru age 5)											
Items	NA	0	1	2	3		NA	0	1	2	3
<i>Challenges</i>						<i>Functioning continued</i>					
Impulsivity/Hyperactivity		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Social and Emotional Functioning		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Developmental/Intellectual		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medical/Physical		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oppositional Behav (36 mos+)	<input type="checkbox"/>	<i>Risk Behaviors & Factors</i>									
Aggressive Behav (24 mos+)	<input type="checkbox"/>	Self-Harm (12 months+)	<input type="checkbox"/>								
Attachment Difficulties		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exploited		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adjustment to Trauma		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Probl Behav (24 mos+)	<input type="checkbox"/>				
Regulatory		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prenatal Care		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Atypical Behaviors		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exposure		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep (12 mos +)	<input type="checkbox"/>	Labor and Delivery		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<i>Functioning</i>						Birth Weight		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Functioning		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Failure to Thrive		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Early Education		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						

For the **Early Childhood Strengths**, use the following categories and action levels:

0 – Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/action plan

1 – Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength

2 – Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful.

3 – An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.

Strengths	NA	0	1	2	3
Family Strengths		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpersonal		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Natural Supports		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resiliency (Persistence & Adaptab.)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship Permanence		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Playfulness		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please write a rationale for any item in the Early Childhood Domain rated actionable ('2' or '3').

TRANSITION AGE YOUTH DOMAIN (Ages 14+)

For the **Transition Age Youth Needs Domains**, use the following categories and action levels:

0 – No evidence of any needs; no need for action.

1 – Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.

2 – Action is required to ensure that the identified need is addressed; need is interfering with functioning.

3 – Need is dangerous or disabling; requires immediate and/or intensive action.

Items	N/A	0	1	2	3		0	1	2	3	
<i>Behavioral/Emotional Needs</i>						<i>Functioning continued</i>					
Interpersonal Problems		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medication Adherence		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Functioning</i>						Intimate Relationships		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Independent Living Skills (K)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transportation		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parental/Coregiving Roles (L)	<input type="checkbox"/>	Educational Attainment		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Job Functioning (M)	<input type="checkbox"/>										

K. INDEPENDENT ACTIVITIES OF DAILY LIVING MODULE (To complete when the Independent Living Skills item is rated '1', '2' or '3'.)

Items	0	1	2	3		0	1	2	3
Meal Preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Money Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Communication Device Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Housing Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

L. PARENTING/CAREGIVING MODULE (To complete when the Parental/Caregiving Role item is rated '1', '2' or '3'.)

Items	0	1	2	3		0	1	2	3
Knowledge of Needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Marital/Partner Viol. in the Home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Involvement with Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

M. VOCATIONAL/CAREER MODULE (To complete when the Job Functioning item is rated '1', '2' or '3'.)

Items	0	1	2	3		0	1	2	3
Career Aspirations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Job Performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Job Attendance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Job Relations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please write a rationale for any item in the Transition Age Youth Domain and related modules rated actionable ('2' or '3').

CAREGIVER RESOURCES & NEEDS DOMAIN (All Ages) Not applicable; no caregiver identified.

0 – No current need; no need for action. This may be a resource for the child/youth.

1 – Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.

2 – Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.

3 – Need prevents the provision of care; requires immediate and/or intensive action.

Caregiver Information

First Name:	Last Name:	Relationship:	0	1	2	3	0	1	2	3
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Supervision			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Involvement with Care			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Developmental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knowledge			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organization			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Resources			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Caregiver Post-traumatic Reactions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Residential Stability			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Marital/Partner Viol. in the Home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical/Physical			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family Relationship to the System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Legal Involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please write a rationale for any item in the Caregiver Resources and Needs Domain rated actionable ('2' or '3').

Caregiver Information									
First Name:	Last Name:				Relationship:				
	0	1	2	3		0	1	2	3
Supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Involvement with Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Developmental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knowledge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Caregiver Post-traumatic Reactions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Residential Stability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Marital/Partner Viol. In the Home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical/Physical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family Relationship to the System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Legal Involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please write a rationale for any item in the Caregiver Resources and Needs Domain rated actionable ('2' or '3').

Caregiver Information									
First Name:	Last Name:				Relationship:				
	0	1	2	3		0	1	2	3
Supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Involvement with Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Developmental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knowledge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Caregiver Post-traumatic Reactions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Residential Stability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Marital/Partner Viol. In the Home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical/Physical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family Relationship to the System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Legal Involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please write a rationale for any item in Caregiver Resources and Needs Domain rated actionable ('2' or '3').

Caregiver Information											
First Name:		Last Name:				Relationship:					
		0	1	2	3			0	1	2	3
Supervision		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance Use		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Involvement with Care		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Developmental		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knowledge		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Safety		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organization		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family Stress		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Resources		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Caregiver Post-traumatic Reactions		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Residential Stability		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Marital/Partner Viol. In the Home		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical/Physical		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family Relationship to the System		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Legal Involvement		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please write a rationale for any item in the Caregiver Resources and Needs Domain rated actionable ('2' or '3').											
<input type="text"/>											

APPENDIX E



Family Disengagement Policy

In times where it has been determined between the Service Coordinator/Wraparound Facilitator and Director that a family has disengaged, i.e. stopped returning correspondence, cancels or does not show up to meetings, etc. The coordinator/facilitator must follow the following steps before officially closing a family out of the program.

1. Three attempts must be made to contact the family. These attempts should be of various types of communication (i.e. text, email, phone) and on varying days/times. Ensure documentation of contact. If return correspondence is not received within three days of contact attempts, move on to step two.
2. Coordinator/Facilitator should reach out to the family team to inquire about alternate ways to contact family or to see if members would be willing/able to contact family. In the case that a family team has not yet been created, Coordinator/Facilitator should reach out to referral source for same requests. If additional contact methods are identified coordinator/facilitator should follow contact rules in step one and wait three days for return correspondence. Ensure documentation for all contact attempts and correspondence with team members. If return correspondence is not received within three days, move on to step 3.
3. Send out Family Disengagement Letter (attached) to the last known address of the family. Keep a copy of the letter in the family's file. The disengagement letter offers a family ten (10) days to respond.

If a return correspondence is not received with the ten (10) day-time frame. notify supervisor and close family from program.

A family may choose to refer to or be referred by an agency in the future but may be subject to wait list if Service Coordinator/ Wraparound Facilitator caseloads are at capacity.

Signature of Parent/ Guardian

Date

Witness/Agency Representative

Date

APPENDIX F



(EXAMPLE)

May 1, 2020

Jane Doe
123 Main St
Norwalk, OH 44857

Ms. Doe,

I hope all is well with you and your family. I am writing to you today because you were referred to our agency by another entity or you have been involved in our Service Coordination/Wraparound program in the recent past. This is a notice that we have attempted to reach you multiple times via email and phone to begin or continue services but have been unsuccessful in doing so.

Due to our inability to contact you, we will assume that you do not have a need for our services at this time.

Please know that you are welcome to call Huron County Family and Children First at any time in the future if you feel that we can be of service to you and your family. Keep in mind that we do accept self-referrals. Referral forms are available on our website: www.huroncountycfc.org or by contacting our agency.

Sincerely,

Yahoska Acosta, ext. 3315
Prevention & Recovery Care Coordinator
Huron County Family & Children First Council
(419) 668-8126
Fax: (419) 668-4738