

Day Treatment & Intensive Outpatient Referral

"Incomplete applications may be returned"

CHILD INFORMATION

Full Name _____ Grade _____ Sex: ☐ Male ☐ Female

Date of Birth _____ Home District _____ SSN _____

EDUCATIONAL REFERRAL SOURCE IDENTIFICATION

Date of Referral _____ Organization Name _____

Name of Person Making Referral _____

Phone _____ Email _____

Street Address _____

City _____ Zip _____

FAMILY INFORMATION

Parent(s)/Guardian(s) #1

First Name _____ Last Name _____

Cell Phone _____ Work Phone _____

Email _____ Relationship to Child _____

Physical Street Address _____

City _____ Zip _____

Parent(s)/Guardian(s) #2

First Name _____ Last Name _____

Cell Phone _____ Work Phone _____

Email _____ Relationship to Child _____

Physical Street Address _____

City _____ Zip _____

Primary language of family spoken at home:

☐ English ☐ Spanish ☐ American Sign Language ☐ Other (describe) _____

RACE/ETHNIC IDENTITY

☐ White

☐ Puerto Rican

☐ Black/African American

☐ Central American

☐ Mexican, Mex-Am, Chicano

☐ American Indian

☐ Dominican

☐ Cuban

☐ Asian/Pacific Islander

☐ Other (describe) _____



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CURRENT LIVING SITUATION

- | | |
|---|---|
| <input type="checkbox"/> Two-parent biological family | <input type="checkbox"/> Kinship Foster Care |
| <input type="checkbox"/> One-parent biological family | <input type="checkbox"/> Relatives Home |
| <input type="checkbox"/> Two-parent adoptive family | <input type="checkbox"/> Psychiatric Inpatient Care |
| <input type="checkbox"/> One-parent adoptive family | <input type="checkbox"/> Crisis Residence |
| <input type="checkbox"/> Foster Care | <input type="checkbox"/> Shelter Care |
| <input type="checkbox"/> Therapeutic Foster Care | <input type="checkbox"/> Day Treatment Program |
| <input type="checkbox"/> Group Home | <input type="checkbox"/> Residential Treatment Center |
| <input type="checkbox"/> Juvenile facility | <input type="checkbox"/> Other (describe) _____ |

CUSTODY STATUS

- | | |
|---|---|
| <input type="checkbox"/> Two biological parents OR
one biological parent and one step-parent | <input type="checkbox"/> Foster parent(s) |
| <input type="checkbox"/> Biological mother only | <input type="checkbox"/> Friends (adult friend) |
| <input type="checkbox"/> Biological father only | <input type="checkbox"/> State Guardianship |
| <input type="checkbox"/> Relatives | <input type="checkbox"/> Other (describe) _____ |
| <input type="checkbox"/> Adoptive parent(s) | |

FAMILY HISTORY

	YES	NO	UNKNOWN
Is there a history of domestic violence/spousal abuse in child's biological family?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there a history of mental illness in child's biological family?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there a history of substance abuse in child's biological family?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does child's current family experience domestic violence/spousal abuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does child's current parent/caretaker have mental illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does child current parent/caretaker have substance abuse issues?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

INSURANCE INFORMATION

Type of health coverage:

- | | | |
|--|--|--|
| <input type="checkbox"/> No insurance | <input type="checkbox"/> Medicaid (ID #) _____ | <input type="checkbox"/> Application Pending |
| <input type="checkbox"/> Medicaid Managed Care Provider (ID #) _____ | <input type="checkbox"/> Private, third party coverage | |
| <input type="checkbox"/> Ineligible | <input type="checkbox"/> Other (describe) _____ | |

CHILD'S INFORMATION

Does child meet eligibility criteria for Serious Emotional Disturbance: ☐ Yes ☐ No

DSM-IV Diagnosis, if known (Please write diagnosis)

Date of Diagnostic Evaluation _____ Person Making Diagnosis _____

IQ Score (if known): Verbal _____ Performance _____ Full Scale _____ Test Date _____



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PSYCHIATRIC HOSPITALIZATION HISTORY

Please provide as much information that is known.

Number of previous hospitalizations _____ ☐ Unknown

Please list all hospitalizations (if known)

NAME OF HOSPITAL	ADMISSION DATE	DISCHARGE DATE	DAYS HOSPITALIZED
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Does child take medication for their mental health?: ☐ Yes ☐ No ☐ Unknown

If yes, list current medication(s) _____

TRAUMA HISTORY

	YES	NO	UNKNOWN
Has child ever been physically abused?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has child experienced emotional abuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has child ever been sexually abused?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CHILD/FAMILY SERVICE SUPPORT INFORMATION

List services child/family receiving (mental health, probation, child-welfare, other community services)

<input type="checkbox"/> Child Protective Services (CPS) Worker _____	Phone _____
<input type="checkbox"/> Children's Mental Health Worker _____	Phone _____
<input type="checkbox"/> Probation Officer _____	Phone _____
<input type="checkbox"/> Mental Health Outpatient Clinic Agency _____	Phone _____
Worker _____	
<input type="checkbox"/> Other Agency _____	Phone _____
Worker _____	
<input type="checkbox"/> Other Agency _____	Phone _____
Worker _____	



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REFERRAL CONCERNS

Screener should consider a child's age, developmental and intellectual level and overall functioning in identifying problems. Check the 2nd column if the problem has been observed within the last month. Check the 3rd column if the problem has ever been observed. Both columns can be checked or left blank.

CHILD'S PROBLEMS

IN LAST MONTH

EVER

1. Excessive irritability	<input type="checkbox"/>	<input type="checkbox"/>
2. Overly sensitive to environment (noise, touch) which causes distress	<input type="checkbox"/>	<input type="checkbox"/>
3. Excessive sadness, crying, withdrawal	<input type="checkbox"/>	<input type="checkbox"/>
4. Excessive fears or worries, difficulty separating from parents, school refusal	<input type="checkbox"/>	<input type="checkbox"/>
5. Recurrent intrusive thoughts or senseless repetitive behaviors, such as hand washing, lock checking, organizing objects	<input type="checkbox"/>	<input type="checkbox"/>
6. Suicidal thoughts, threats, gestures or attempts	<input type="checkbox"/>	<input type="checkbox"/>
7. Hallucinations (sees or hears things that aren't there), delusions (has strong beliefs which have no basis in reality)	<input type="checkbox"/>	<input type="checkbox"/>
8. Difficulty in concentration	<input type="checkbox"/>	<input type="checkbox"/>
9. Irregular or problematic sleep patterns	<input type="checkbox"/>	<input type="checkbox"/>
10. Many nightmares	<input type="checkbox"/>	<input type="checkbox"/>
11. Irregular or problematic eating/appetite patterns	<input type="checkbox"/>	<input type="checkbox"/>
12. Problems in activity patterns (over-active or under-active)	<input type="checkbox"/>	<input type="checkbox"/>
13. Injures self, e.g., cutting , head-banging	<input type="checkbox"/>	<input type="checkbox"/>
14. Enuresis or Encopresis (wetting or soiling)	<input type="checkbox"/>	<input type="checkbox"/>
15. Inability to give or receive appropriate affection to primary caregivers	<input type="checkbox"/>	<input type="checkbox"/>
16. Inability to accept appropriate limits	<input type="checkbox"/>	<input type="checkbox"/>
17. Easily angered or excessive anger or other strong emotion.	<input type="checkbox"/>	<input type="checkbox"/>
18. Frequent, intense, uncontrollable temper tantrums	<input type="checkbox"/>	<input type="checkbox"/>
19. Verbally threatening	<input type="checkbox"/>	<input type="checkbox"/>
20. Physically violent	<input type="checkbox"/>	<input type="checkbox"/>
21. Cruel to animals	<input type="checkbox"/>	<input type="checkbox"/>
22. Willful destruction of property	<input type="checkbox"/>	<input type="checkbox"/>
23. Fire setting	<input type="checkbox"/>	<input type="checkbox"/>
24. Sexually preoccupied or inappropriate sexual activity	<input type="checkbox"/>	<input type="checkbox"/>
25. Running away	<input type="checkbox"/>	<input type="checkbox"/>
26. Suspected or confirmed abuse of alcohol or other drugs/substances	<input type="checkbox"/>	<input type="checkbox"/>
27. Adolescent's pregnancy is/was related to behavioral/emotional difficulties	<input type="checkbox"/>	<input type="checkbox"/>
28. Parenting (Youth is having trouble parenting his/her child(ren))	<input type="checkbox"/>	<input type="checkbox"/>
29. Medical condition complicated by emotional disturbance or medical noncompliance	<input type="checkbox"/>	<input type="checkbox"/>



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REFERRAL CONCERNS CONTINUED

CHILD'S PROBLEMS

	IN LAST MONTH	EVER
30. Persistent unrealistic worry over physical health	<input type="checkbox"/>	<input type="checkbox"/>
31. Problems in school/vocational activity (attendance, behavior, learning, performance)	<input type="checkbox"/>	<input type="checkbox"/>
32. Suspected or confirmed victim of physical, sexual or emotional abuse	<input type="checkbox"/>	<input type="checkbox"/>
33. Problems in interpersonal relationships (family and/or authority figures)	<input type="checkbox"/>	<input type="checkbox"/>
34. Problems in interpersonal relationships (same age peers)	<input type="checkbox"/>	<input type="checkbox"/>
35. Confirmed or suspected developmental delay	<input type="checkbox"/>	<input type="checkbox"/>
36. Arrested, detained, or on probation	<input type="checkbox"/>	<input type="checkbox"/>
37. Homicidal	<input type="checkbox"/>	<input type="checkbox"/>
38. Gambling	<input type="checkbox"/>	<input type="checkbox"/>
39. Avoids people, places or things	<input type="checkbox"/>	<input type="checkbox"/>
40. Always seems jumpy or afraid	<input type="checkbox"/>	<input type="checkbox"/>
41. Gets upset when remembering bad thing that have happened to him/her.	<input type="checkbox"/>	<input type="checkbox"/>

PROVIDE INFORMATION ABOUT THREE BEHAVIORS OR CONCERNS THAT PROMPTED THIS REFERRAL

(Include Any Supporting Data Collected)

Behavior or concern #1 (And frequency in which it is observed. I.e. 4x day)

Behavior or concern #2

Behavior or concern #3



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CURRENT EDUCATION PLACEMENT AND INFORMATION

☐ Special education-in-district program/service ☐ Day treatment-out-of-district

☐ Home School

☐ Pre-school

☐ Other (describe) _____

Percent of day in setting III or a federal setting V-VIII (Residential, Homebound, Hospital) _____

First Day at this placement _____

School District _____ Name of School _____ Grade _____

Special Education Case Manager _____ Phone _____ Email _____

District Representative _____ Phone _____ Email _____

Signature of District Representative _____ Date _____

*Your signature acknowledges that your district will:

1. Provide transportation (school year and if ESY eligible).
2. Plan for alternate placement if the student refuses to participate or is no longer making progress toward ITP and IEP goals. (Refusing MH service, non-attendance, substance abuse)
3. Plan appropriate programming if/when the student graduates from WIN programming.

SPECIAL EDUCATION CLASSIFICATION

☐ Emotionally & Behaviorally Disorder

☐ Other Health Disability

☐ Learning Disabled

☐ Multiple Handicapped

☐ Hearing Impaired

☐ Pre-School Special Education (DD)

☐ Physically Disabled

☐ Unknown

OTHER SCHOOL BEHAVIORS AND CONCERNS

☐ Truancy/attendance

☐ Poor teacher interaction

☐ Failing grades

☐ Physical aggression

☐ Frequent suspensions

☐ Other (describe) _____

☐ Poor peer interaction

Number of Out of School Suspension _____ Number of In School Suspension _____

Number of restrictive procedures in the current school year _____



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ACADEMIC DATA

READING

Estimated Grade Level _____

Skill Deficits _____

Skill Strengths _____

Current MCA Test Results: Score _____ ☐ Did Not Meet ☐ Partially Met ☐ Met

Current Coursework (Curriculum) _____

MATH

Estimated Grade Level _____

Skill Deficits _____

Skill Strengths _____

Current MCA Test Results: Score _____ ☐ Did Not Meet ☐ Partially Met ☐ Met

Current Coursework (Curriculum) _____

STRENGTHS

Please indicate the family's strengths that may be utilized to assist the child with services

Please list child's strengths, interests, hobbies, activities



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PLEASE COMPLETE AND ATTACH THE FOLLOWING:

- ☐ Current signed copy of release of information for educational records at residential treatment center/hospital.
- ☐ Current signed copy of release of information between referring district and Minnewaska Area W.I.N. Academy
- ☐ Obtain education records from residential treatment center/hospital.
- ☐ Current signed copy of release of information for diagnostic assessment.
- ☐ Current signed copy of release of information for county worker/social worker.
- ☐ Updated High School Transcript from home district and treatment center/hospital.
- ☐ Immunization Records
- ☐ Current Evaluation Report(not due within the next 6 months)
- ☐ Behavior Intervention Plan
- ☐ Current IEP with any amendments and updated Present Level(s) of Academic Achievement and Functional Performance.
- ☐ Current Prior Written Notice after acceptance proposing a setting IV placement at Minnewaska Area W.I.N. Academy with mental health services. There needs to be a statement on why W.I.N. Academy is the least restrictive setting and other options considered.
- ☐ Pending acceptance into Minnewaska Area W.I.N. Academy the IEP Service Times need to be reflected prior to starting.

