**Truancy and Delinquency Prevention Partnership Referral Form**
**( ) Norristown ( ) Montgomery County ( ) Delaware County**

**Please complete this form to the best of your knowledge & send it to Cynthia Rooney, Coordinator.**
**CGRC 2000 Old West Chester Pike Havertown, PA 19083 Fax: (484) 454-8706**
**Direct questions to Cynthia Rooney at: (484) 454-8700 extension 1426, or: crooney@cgrc.org**

Which member of the child's family was notified of this referral? ______________________ When? _____
Did they agree? ______
Referring person, title, and agency: ______________________________________________
Phone: ( ) ________________________ Fax: ( ) ________________________
Address: ______________________________________________________________
Best contact person at school on this child: ______________________________________
Phone: ( ) ________________________ Fax: ( ) ________________________
Address: ______________________________________________________________
Email address: __________________________________

Child's Name: ______________________ **DOB**: __________ SS#: ______________
Ethnicity: ___________________ **Grade**: __________ Gender: ________________
School District: ___________________ Child's Current School: ____________________

Does the child live with both biological parents? ☐ YES ☐NO If no, why not? ______________
Are the biological parent's rights terminated or intact (terminated by court)? ☐TERMINATED ☐IN TACT
Do the biological parents have contact with the child? ☐ YES ☐NO In what capacity? __________
Is there ☐CYS ☐DHS ☐DYFS ☐OCY or, ☐private foster care agency involvement with this child?
Caseworker Name / Phone / Fax #: ____________________________________________
Is there a legal custody agreement signed by a Judge or Master? An adoption decree? ☐ YES ☐NO
If yes, please provide documentation.

Child's Guardian(s): Name(s): ________________________________ Relation to child: __________
Address: ______________________________________________________________
Phone: ( ) ________________________ Alternate Phone: ( ) ________________
Email address: ___________________________________________________________

Other relevant family information (including contacts): ______________________________
______________________________________________________________________
Please identify strengths of the child and the family: _______________________________
______________________________________________________________________
Has the child ever had any mental health services, CYS, OCY, Juvenile Court involvement, or Truancy Court involvement? ______________________________________________________
Describe dates, services involved, agencies involved, workers involved, and outcomes: __________
______________________________________________________________________
Does the child have any upcoming court dates? __________ When? ____________________
For what issues? ________________________________________________________
Describe contacts with and involvement of parents / guardians: ________________________
______________________________________________________________________

Describe the child's school attendance currently and in the past – to include total number of absences, total number of illegal absences, and total number of days tardy for the previous academic year, if you wish: ______

______________________________________________________________________

Number of excused days absent this school year: _______ Number of illegal absences this school year: ______
Number of days tardy this school year: _______ Number of days illegally tardy this school year: _______

Describe the child's behavior at school: ______________________________
Describe the child's behavior at home: ______________________________

Describe interventions the school or other agencies have employed to rectify problem behaviors: __________

______________________________________________________________________

Is the school's Student Assistance Program involved? ______________________
Has the child received any mental health or drug and alcohol evaluations? ______________
What did those evaluations recommend? ______________________
Does the child have any significant medical issues? ______________________
Describe: ______________________________________
Is the child taking any medications? ______________________
What and why? ______________________________________
Has the child been tested for special education services? ______________________
Does the child have an IEP or other plan?______________________
Describe accommodations outlined in the child's IEP or other plans (i.e. LS / ES; Part / Full-time; itinerant; behavior plan; etc.): ______________________

______________________________________________________________________

Describe disciplinary actions taken for this child, including number of detentions, ISS, and OSS: __________

______________________________________________________________________

Are a citation for Truancy Court and School Attendance Improvement Plan attached? ______________

**Thank you for your time and consideration in making this referral. If you feel it would be helpful, please attach any attendance records, report cards, teacher feedback reports, disciplinary write-ups, behavior plans, evaluation reports, IEP's, SAIP's or other relevant documents to this referral.**

**If the child you are referring is under the age of 14 years old and is being cared for by someone other than his/her biological parent, appropriate verification of guardianship must be done prior to service implementation. Please attach any/all custody documentation in your possession to this referral.**

**Delivery of services to families will depend on the current waiting list and the family's willingness to cooperate. Please inform the child and guardian of this referral and have them sign the attached release for your school or agency. If this is not possible, please mail the attached release with a letter of intent to the client's home. You can contact the Coordinator with updated information prior to establishing communication with an assigned Truancy Worker.**

**We do not take children to school. We stay open for about 6 months of services including weekly, in-home family therapy, weekly individual therapy with the identified child at school, on-going case management and resource coordination to set supports, and advocacy at school meetings and court. We are mobile and can transport. We have some funds for basic needs and enrollment fees. We are a child welfare program operating from a mental health treatment point of view. The parent/guardian is just as much of a client as the identified child. It takes a family effort to make change last. The County Children and Youth Agency is notified of referred families who do not open for services.**

# CHILD GUIDANCE RESOURCE CENTERS

## Authorization for Release of Information



Client Name: ______________________ Medical Record #: ______________________

Address: ______________________

Social Security #: ______________________ Date of Birth: ______________________

**Authorization:**

I hereby authorize Child Guidance Resource Centers **to release and disclose** my information by mail, email, courier, or fax:

**FROM:**
CHILD GUIDANCE RESOURCE CENTERS
2000 OLD WEST CHESTER PIKE, HAVERTOWN, PA 19083

**TO:**
______________________
______________________

I hereby authorize Child Guidance Resource Centers **to obtain** my information by mail, email, courier, or fax:

**FROM:**
______________________
______________________

**TO:**
CHILD GUIDANCE RESOURCE CENTERS
2000 OLD WEST CHESTER PIKE, HAVERTOWN, PA 19083

**Reason for disclosure:**

☒ referral ☐ continuity of care ☐ verbal communication ☐ parents records ☐ Other ______________________

**Information to be disclosed: (Individual must check each appropriate section)**

☒ **Mental Health** ☒ **Yes** ☐ **No or Not Applicable**

Information released / obtained: Psychiatric/Psychological Evaluation(s), Biopsychosocial/Functional Behavior Assessment(s), Medical History, Medication Orders, Discharge Summary

This information will be disclosed from records protected by Pennsylvania State law. Pennsylvania law prohibits further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or is authorized by the Confidentiality of HIV Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.

☒ **Education Records** ☒ **Yes** ☐ **No or Not Applicable**

Information released / obtained: IEP, ER, Report Card(s), Daily Academic and Behavioral Goal Sheets, Behavior Plans, School Observations, Attendance, Disciplinary Records, On-going verbal communication

This information will be disclosed from records protected by Pennsylvania State law and the Family Educational Rights and Privacy Act of 1974.

☒ **Drug & Alcohol** ☐ **Yes** ☒ **No or Not Applicable**

Information released / obtained: Dates of Service, Prognosis, Treatment Recommendations, Relapse

This information will be disclosed from records protected by Federal Confidentiality rules (42 CFR Part 2). The Federal rules prohibit the individual or organization identified on this form from making any further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR 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.

☒ **HIV** ☐ **Yes** ☒ **No or Not Applicable**

Information released / obtained: Coordination of Care / Clinical Profile

This information will be disclosed from records protected by Pennsylvania State law. Pennsylvania law prohibits further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or is authorized by the Confidentiality of HIV Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.

☒ **Demographic information** ☐ **Yes** ☒ **No or Not Applicable**

Specifically: ______________________________

**This authorization expires as indicated:** From ______________ to ______________ (not to exceed one year).

**I understand that:**

- This consent is voluntary. I may refuse to sign this form.
- This authorization may be revoked at any time in writing to the individual / organization identified in this authorization except to the extent that information has already been disclosed. If information has already been disclosed in reliance on this authorization, revoking it will only prevent future disclosure.
- CGRC, its programs, services, employees, officers, and contractors are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.
- None of the information released will be used to support any criminal charges or conduct an investigation of me, without a court order.
- If I do not sign this form my treatment team may not receive information that could be important to my treatment.
- If I do not sign this form a delay in treatment or an unknown impact on treatment and care could result.

**Authorized Signature(s):**

______________________________ ______________
Client Signature (if 14 years of age or older) Date

______________________________ ______________
Parent / Legal Guardian Signature Date

**FOR DRUG AND ALCOHOL TREATMENT PARENT / LEGAL GUARDIAN SIGNATURE IS NOT APPLICABLE UNDER ACT 63**

______________________________ ______________
Witness Signature Date

If individual is physically unable to sign, signature of second witness: ______________________________

**THIS AUTHORIZATION IS NOT VALID UNLESS ALL SECTIONS ARE COMPLETED**