PARENT SUPPORT PARTNER REFERRAL FORM

CFP Parent Support Partner Eligibility Criteria

- ☐ Youth aged 0-21
- ☐ Mental Health diagnosis and moderate/severe functional impairment measured by the CAFAS/PECFAS/DECA-C for a period of six months **OR** diagnosis of an Intellectual/Developmental Disability

1. **Child/Youth Name:** _____
   Last **First** **MI**
2. **Child/Youth Date of Birth:** _____/_____/_____
3. **Child/Youth Network180 Number:** _____ **DHHS Medicaid ID Number:** _____
4. **Does youth have active Medicaid?** ☐ Yes ☐ No *(Not required for service)*
5. **What sex was the youth assigned at birth, on the original birth certificate?** ☐ Male ☐ Female
6. **Current Gender Identity: how does the youth describe themselves? (Check one)**
   ☐ Male ☐ Female ☐ Transgender ☐ Does not identify as female, male, or transgender
7. **Sexual Orientation? (Check one)**
   ☐ Heterosexual/Straight ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Unknown/Other
8. **Name of parent/caregiver requesting the PSP Services:** _____
9. **Phone:** _____ **Current Street Address:** _____

   Email Address: _____
10. **Please indicate current/ongoing multi-system involvement:**
    ☐ Juvenile Justice: Open Case? ☐ Yes ☐ No Probation Officer: _____Phone: _____
    ☐ CPS - DHHS: CPS Worker: _____ Phone: _____
    ☐ Current/Open Child Abuse and Neglect Investigation Category: ☐ I ☐ II ☐ III ☐ IV
    ☐ In-Home Services (specify): _____
    ☐ Foster Care: Case Manager: _____ Phone: _____
    ☐ Mental Health: Therapist & Agency: _____ Phone: _____
    ☐ Education: ☐ Special Education/IEP ☐ 504 Behavioral Plan ☐ Other: _____
    School Contact & Role: _____ Phone: _____
11. **Medical: Is child/youth healthy? Yes No (Circle one)**
    ☐ Child has an ongoing medical condition requiring coordination (diabetes, cancer, severe asthma, etc.)?
    Describe Condition: _____
    Coordinating Physician/Specialist: _____ Phone: _____
12. **Reason for referral: (Please use these examples when developing PSP strategies for the IPOS / Addendum)**
    - ☐ Understanding child's diagnosis
    - ☐ Learning new parenting skills
    - ☐ Communicating with other service providers
    - ☐ Increasing connection to natural supports & community resources
    - ☐ IEP/school support
    - ☐ Understanding rules and roles of systems
    - ☐ Self-care
    - ☐ Support and encouragement
    - ☐ Learning advocacy skills
    - ☐ Other: _____

13. **Any specific requests that will help us match a PSP? (male/female, race, experience, etc.)**

_____
_____
_____

14. **Most recent CAFAS/PECFAS: Date: _____ Total Score:_____ ☐ Not Applicable (I/DD)**
School: _____ Home: _____ Comm: _____ Behavior: _____ Moods: _____ Self-Harm: _____ SA: _____ Thinking: _____
Caregiver scored: _____ Relationship to youth: _____ Material: _____ Support: _____

Name of person initiating CFP Referral: _____ Organization: _____
Source of referral: ☐ Juvenile Justice ☐ DHS ☐ MH Provider ☐ Foster Care ☐ KSSN ☐ Education ☐ net180 ☐ Other:_____

Phone Number: _____ E-mail: _____

Relationship to child/youth: _____ Date Referral Submitted: _____
If different, name of person completing this form: _____ Organization: _____

Names of Children/Youth (please print):	network180 ID:

TO BE COMPLETED BY PARENT/GUARDIAN:

Caregiver/Guardian Name (please print): _____

Caregiver/Guardian Signature (please sign): _____

Date signed: | _ _ | **/** | _ _ | **/** | _ _ _ _ |

***Please Fax form along with current Demo/Financial, executed IPOS/addendum with PSP in grid & strategies, as well as the Current Assessment with CAFAS to 616-336-3593.**