DPBHS Intake Services
HIGHER LEVEL OF CARE REFERRAL
Required Referral Information

****If you feel your child is in crisis, call Mobile Response Stabilization Services (Child Crisis Hotline) at 1-800-969-4357** This service is available to all families regardless of insurance.**

If you have questions or need assistance completing this form, please call 1-800-772-7710 Monday through Friday 8-4:30 or email the DSCYF_Intake_General@delaware.gov mailbox and an Intake Team member will contact you.

Your child may be eligible for services through DPBHS if they:

- **are a Delaware resident and under age 18**
- **are uninsured or covered by Delaware Medicaid or both private insurance and Medicaid**
- **have a mental health and/or substance use diagnosis**

- Please make every effort to answer all the questions in this packet to help us make the best determination for services.
- **The additional documentation listed below, is required to process the request for services:**

  □ If the child is covered by private Insurance, please include a Summary of Benefits and Coverage, including mental health and/or substance abuse coverage. This can usually be obtained by calling your insurance provider.

  □ If the child has a legal guardian, please include a copy of the court order awarding guardianship.

What to expect:

- You will receive a confirmation call or email within two business days from an Intake Team member to confirm receipt of this referral. If you have any questions, please call or email us at 1-800-722-7710 or DSCYF_Intake_General@delaware.gov.

- Once all necessary documentation and signatures are received, we will work to process your request within two weeks.

Thank you for your referral and we look forward to working with you.

DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH & THEIR FAMILIES
DIVISION OF PREVENTION & BEHAVIORAL HEALTH SERVICES
Terry Center Pod 3, 10 Central Ave., New Castle, DE 19720
1-800-722-7710

DPBHS Intake Services

HIGHER LEVEL OF CARE REFERRAL

Please fill out this form as completely as possible.

The completed form can be faxed to (302) 622-4475, emailed to DSCYF_Intake_General@delaware.gov or mailed to the address above.

CHILD/YOUTH INFORMATION

Today's date:_____ Child's Name: _____

DOB: _____ Gender: ☐ M ☐ F Race:_____ Ethnicity: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Child's preferred language: _____

School:_____Grade:_____ Education Type: ☐ Regular ☐ Special

PARENT/GUARDIAN INFORMATION

Name:_____ DOB: _____

Relationship to Child**: _____

** If you are not the parent, please include a copy of the guardianship document(s) and/or court order(s) this documentation is needed to complete this referral.

Address: _____

City:_____ State:_____Zip: _____

Best Phone Number:_____Other Phone: _____

Email: _____

INSURANCE INFORMATION

Active Medicaid: (Highmark Health Options, Amerihealth Caritas, Delaware First Health)?

☐ Y ☐ N Member ID Number: _____

Private Insurance**: (Aetna, BCBS, etc.):

☐ Y ☐ N If yes, name of company: _____

Member ID Number: _____

** Please include a summary of mental health/substance abuse benefits available through your child's private insurance provider – this documentation is needed to complete this referral.

BEHAVIORAL HEALTH TREATMENT INFORMATION

CURRENT AND HISTORY OF MENTAL HEALTH AND/OR SUBSTANCE ABUSE TREATMENT

Provider	Treatment Type (Outpatient/Inpatient/Psychiatry/Etc.)	Begin Date	End Date	Helpful?

CURRENT MEDICATION

Provider	Medication Name	Dosage

IF REFERRAL IS BEING COMPLETED BY SOMEONE OTHER THAN THE PARENT/GUARDIAN, PLEASE COMPLETE THIS SECTION

Completed by:_____Organization/Agency: _____

Relationship to Child:_____Position: _____

Email:_____Phone: _____

Signature: _____

AUTHORIZATION SIGNATURE(S) -- REQUIRED

I give permission for the information in this referral to be given to DPBHS. I give permission for DPBHS to:

1. Contact people or agencies listed in this referral to obtain further information as needed
2. Share this information with the Medicaid office if DPBHS believe that my child may be eligible for the Delaware Children's Community Alternative Disability Program https://dhss.delaware.gov/dmma/disabledchildren.html
3. Share this information with authorized service providers if my child is eligible for DPBHS services.

***Parent/Guardian Signature: _____ Date: _____**

****Youth Signature if 14 years or older: _____ Date: _____**

**** Required for clients 14 or older seeking substance use treatment**

***If verbal consent is given, it must read: "Verbal consent given by (specific name) and witnessed by (specific name)".**

Current Behavioral Health Functioning

RISK OF HARM

In the past 30 days, has the child had…	Current (30 days)	Past	Never	*In the past 30 days, has the child had…*	Current (30 days)	Past	Never
Suicidal Ideation	☐	☐	☐	Physical Aggression (person)	☐	☐	☐
Suicidal Plan	☐	☐	☐	Physical Aggression (objects)	☐	☐	☐
Suicide Attempt	☐	☐	☐	Homicidal Threat	☐	☐	☐
Self-Injury	☐	☐	☐	Homicidal Attempt	☐	☐	☐
Inappropriate Sexual Behaviors	☐	☐	☐	Fire setting	☐	☐	☐
Substance Use	☐	☐	☐	Cruelty to Animals	☐	☐	☐

If any of the above are checked please provide description and details as to the risk behaviors including frequency/intensity/ duration and any triggers if known:

_____
_____
_____
_____
_____

Please explain why more than outpatient services are needed:

_____
_____
_____
_____

FUNCTIONAL STATUS

Identify how the youth is functioning at home, in school, and in the community and provide details.

_____
_____
_____
_____
_____

List youth's mental health and/or substance use diagnoses.

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

CO-OCCURRING CONDITIONS

Developmental* YES ☐ NO ☐

Medical YES ☐ NO ☐

*** If yes to any of these conditions, please, include a psychoeducational, neurological, or other evaluation indicating functioning, ability, and cognitive testing.**

If either or both of the above are checked yes, please list diagnoses and provide any additional information including the relationship between the child's behavioral health and co-occurring conditions.

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

RECOVERY ENVIRONMENT *(to include family, friends, natural supports, school, medical services, juvenile justice, child welfare, and community resources)*

Describe the environmental **stress** for this youth and their family (e.g., housing, financial, recent family deaths or other trauma):

Describe the environmental **supports** for this youth and their family (e.g., teachers/mentors, athletics, faith based, friends):

RESILIENCY AND/OR RESPONSE TO SERVICES

Describe how the youth has responded to treatment and support services:

List the strengths, interests, and protective factors that the youth and their family possess:

INVOLVEMENT IN SERVICES

Please describe the youth's engagement in current and past services (please include examples):

Please describe the parent/caregiver's engagement in current and past services (please include examples):

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Aged 6–17

Child's Name: _____ **Age:** _____ **Sex:** ☐ **Male** ☐ **Female** **Date:** _____

Relationship with the child: _____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child …						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			

CONSENT FOR RELEASE OF CONFIDENTIAL MENTAL HEALTH INFORMATION
DIVISION OF PREVENTION & BEHAVIORAL HEALTH SERVICES

Client Name:_____DOB:_____

I, (Parent/Guardian/Custodian/DFS)_____hereby authorize the Division of Prevention and Behavioral Health Services (DPBHS) to Release Verbal/Written Information to and to receive verbal and written information from:

Agency name or school:_____
Name of contact person at agency/school (if known):

Verbal and written information to be released by DPBHS: (Check all items that apply.)

- ☐ Admission / Discharge Summaries (DPBHS services for past 2 years)
- ☐ Service Admission Form (includes Demographics, CSM Service Plan, DPBHS Treatment History, Medication History, Risk Factors)
- ☐ DPBHS Psychosocial Evaluation ☐ DPBHS Psychological Evaluation ☐ DPBHS Psychiatric Evaluation
- ☐ Educational Records ☐ Treatment Progress/Summary
- ☐ Most recent physical exam (not to include pregnancy, STD, HIV information)
- ☐ Other: _____

The purpose of this information disclosure by DPBHS is to: (Check all items that apply.)

- ☐ Make a referral/provide treatment by the clinical treatment organization or person listed above
- ☐ Assist in the completion of PBHS Evaluation(s)
- ☐ Provide clinical information to organization or person named above

Verbal and written information to be released to DPBHS: (Check all items that apply.)

- ☐ Initial Evaluation ☐ Comprehensive Treatment Plan ☐ Discharge Summary
- ☐ Treatment Progress Summary ☐ Physical Examination ☐ Speech and Language Evaluation
- ☐ Neurological Evaluation ☐ Medication History ☐ Psychiatric Evaluation
- ☐ Most recent educational records including educational testing and school psychological, IEP/IPRD documents, school attendance and behavioral/disciplinary records
- ☐ Other _____

The purpose of this information disclosure by the agency/school named above is to: (Check all items that apply.)

- ☐ Enable PBHS to Plan, Monitor, Authorize Payment, Coordinate Care with Treatment Provider
- ☐ Enable PBHS to use the educational material in planning treatment
- ☐ Enable PBHS to collaborate with the school in planning and providing services
- ☐ Assist in the completion of PBHS Evaluation(s)

I understand that this form can not be used to release information about drug and alcohol treatment, pregnancy, HIV status, and sexually transmitted diseases.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present it to the Director of Quality Improvement in the Division of Prevention of Behavioral Health Services. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this release in order to be assured treatment. I understand that I may inspect or copy the information used or disclosed as provided in 45 C.F.R. 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and that the information may not be protected by federal confidentiality rules. If I have any questions about the disclosure of my health information, I can contact the Director of Quality Improvement, Division of Prevention and Behavioral Health Services.

This Release of Information demonstrates compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 C.F.R. pts. 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Once the requested Personal Health Information (PHI) is disclosed, the recipient may re-disclose it, therefore the privacy regulations may no longer protect it.

This authorization is valid for one year from the signature date unless revoked.

_____ _____
Parent, Guardian, Custodian, DFS Signature (Circle one) Print Name/Date

_____ _____
DSCYF Representative Signature Print Name/Date

DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH & THEIR FAMILIES
DIVISION OF PREVENTION & BEHAVIORAL HEALTH SERVICES
1825 Faulkland Road, Wilmington, DE 19805

CONSENT FOR THE RELEASE OF CONFIDENTIAL ALCOHOL OR DRUG TREATMENT INFORMATION

I,_____, authorize
(Print name of youth)

Please check appropriate box:

- ☐ Division of Family Services (DFS)
- ☐ Division of Youth Rehabilitation (YRS)
- ☐ Parent / Guardian
- ☐ Family Court
- ☐ Superior Court
- ☐ Department of Education (DOE)
- ☐ Multi Disciplinary Team (MDT)
- ☐ Deputy Attorney General's Office (DAG)
- ☐ Public Defender (PD) / Private Attorney (PA)
- ☐ Other (Please specify): _____

☐ To disclose ☐ To receive from the Division of Prevention and Behavioral Health Services the following information:

All information pertinent to substance abuse, including verbal communication, treatment progress and assessment, drug screen reports, and discharge summary.

The purpose of the disclosure authorized herein is to: Assist in completion of Prevention and Behavioral Health Services evaluation(s), treatment recommendations, and / or placement.

I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent, unless otherwise provided for in the regulations. I have the right to receive a copy of this form after completing it. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event, this consent expires automatically as follows:

THIS AUTHORIZATION WILL EXPIRE TWELVE (12) MONTHS FROM DATE OF SIGNATURE

_____	_____	_____
Signature of Youth (mandatory for 14 years and older)	Print Name of Youth	Date
_____	_____	_____
Signature of Parent or Guardian (mandatory if client under 14 years old)	Print Name of Parent or Guardian	Date

PROHIBITION ON REDISCLOSURE OF INFORMATION CONCERNING CLIENT IN ALCOHOL OR DRUG ABUSE TREATMENT

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with consent of such a client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making further disclosure 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.

Caregiver Strain Questionnaire-Short Form 7

How are YOU?

NAME OF YOUR CHILD: _____

Please think back over the <u>past month</u> and try to remember how things have been for <u>your family</u>. We are trying to get a picture of how life has been in your household over that time.

For each question, please tell me which response (which number) fits best.

In the past month, how much of a problem was the following:

		Not at all	A little	Somewhat	Quite a bit	Very much
1.	Interruption of personal time resulting from your child's emotional or behavioral problem?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2.	Disruption or upset of relationships within the family due to your child's emotional or behavioral problem?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3.	You missing work or neglecting other duties because of your child's emotional or behavioral problem?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4.	Financial strain for your family as a result of your child's emotional or behavioral problem?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

In this section, please continue to look back and try to remember how <u>you</u> have felt during the <u>past month</u>. For each question, please tell me which response (which number) fits best.

In the past month:

		Not at all	A little	Somewhat	Quite a bit	Very much
5.	How worried did you feel about your child's future?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6.	How sad or unhappy did you feel as a result of your child's emotional or behavioral problem?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
7.	How tired or strained did you feel as a result of your child's emotional or behavioral problem?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5