

**REQUIREMENTS FOR ALL MULTI-DISCIPLINARY  
AND SCREENING COMMITTEE PRESENTATIONS**

1. The common intake form must be filled out in its entirety.
2. This packet **must** include a letter from the child’s current therapist updating the child’s status if a therapist is involved. It is recommended, if you are requesting a placement, that you include other pertinent information such as a social history, probation report, psychologicals and school information. If these do not already exist, we do not want you to create them just for the presentation. It is not the Team’s desire to create more paperwork but this information will usually be in the file if the child is at a stage where placement outside the home is needed. Brad Welch will review the information you have compiled if you give the packet to him in advance or discuss with you what type of information would be helpful to your presentation.
3. The attached form should be filled out for a presentation to the Multi-Disciplinary Team or Screening Committee
4. The Multi-Disciplinary Team meets on the first Thursday of every month at noon. This meeting usually takes place at the Gauga County Board of Mental Health and Recovery Services offices. A case should be presented to the Multi-Disciplinary Team if you seek treatment recommendations for residential placement or for therapeutic foster care. Any case can be presented including those difficult cases for which you may just want some direction or suggestions.
5. The Screening Committee meets every Monday at 11:00 a.m. at the Gauga County Board of Mental Health and Recovery Services offices. The Screening Committee also serves as the Emergency Multi-Disciplinary Team. The Screening Committee is the entry point for all Council-funded programs, which include Bridges and the Therapeutic Youth Center. The purpose of the Emergency Multi-Disciplinary Team is to accommodate those cases that need to be presented before the first of the month, i.e. a child in need of an emergency placement.
6. Because, by definition, all children presented for acceptance into Council-funded programs or for case funding have multiple needs, it is likely that a treatment team is already working together on behalf of the child.

Please list all current treatment team members:


**Please encourage the parents and all treatment team members to participate in the planning and presentation of the case.**

7. If there are dissenting opinions on the treatment team as to the best course of action, the people holding those opinions should participate in the case presentation. (NOTE: There is nothing wrong with presenting Plan A and Plan B and asking the Multi-Disciplinary Team or Screening Committee to decide and/or give input.)
8. Please bring **8 packets** of materials to the Screening Committee and **10 packets** to the Multi-Disciplinary Team.
9. A lead case manager needs to be identified for each case. The lead case manager is the person who will assume primary responsibility for insuring that services are coordinated and delivered. The lead case manager will follow the Notice Requirements (ORC2151.55-2151.554) for all out-of-county foster home placements. Please contact your agency’s representative to the Multi-Disciplinary Team for these requirements.

The following components **are necessary** for any Treatment Team meeting to go forward. The presenter or LCM from an agency is responsible for the following notifications:

- Was family invited to the meeting?  Yes  No
- Was family reminded they could bring a support person?  Yes  No  
(If family wants to bring attorney, **24-hour notice** is required.)
- Was appropriate school official notified of meeting?  Yes  No
- Did presenter/LCM notify appropriate staff and involved agencies?  Yes  No

Referral Time-Line

- 1) Referral is received from a family member or an agency staff person who is contacted by the next business day by the Case Services Coordinator.
- 2) After determining the appropriateness of the referral the initial inter-disciplinary team meeting is usually scheduled within 5 business days or less.
- 3) The case is presented and the recommendations from the Team hearing the presentation are then sent to the presenter, the family (if the family is not the presenter) and to other appropriate parties within 5 business.

Lead Case Manager: \_\_\_\_\_  
Date of receipt of referral: \_\_\_\_\_

Release Signed: \_\_\_\_\_

**INTAKE FORM  
GEAUGA COUNTY FAMILY FIRST COUNCIL  
12480 RAVENWOOD DRIVE  
CHARDON, OH 44024**

**FAMILY NAME:** \_\_\_\_\_

**DATE PRESENTED:** \_\_\_\_\_ **PRESENTER:** \_\_\_\_\_

**LEAD CASE MANAGER:** \_\_\_\_\_

ALL HOUSEHOLD MEMBERS	DOB (Age)	DOB (Age)
1. _____ (Father)	( )	4. _____ ( )
2. _____ (Mother)	( )	5. _____ ( )
3. _____	( )	6. _____ ( )

**FAMILY ADDRESS:** \_\_\_\_\_ **FAMILY PHONE:** \_\_\_\_\_

\_\_\_\_\_ **BEST TIME/DAY TO CONTACT:** \_\_\_\_\_

**PRIMARY SOURCES OF FINANCIAL SUPPORT FOR FAMILY: FOR PARENTS/GUARDIANS: IF EMPLOYED, PLEASE LIST THE FOLLOWING INFORMATION ABOUT EMPLOYER:**

- |  |  |              |
|--|--|--------------|
| <input type="checkbox"/> EMPLOYMENT      | <input type="checkbox"/> UNEMPLOYMENT COMP | NAME: _____  |
| <input type="checkbox"/> SOCIAL SECURITY | <input type="checkbox"/> WORKMENS COMP.    | PHONE: _____ |
| <input type="checkbox"/> S.S.D.          | <input type="checkbox"/> CHILD SUPPORT     | NAME: _____  |
| <input type="checkbox"/> S.S.I.          | <input type="checkbox"/> ALIMONY           | PHONE: _____ |
| <input type="checkbox"/> OWF (ADC)       | <input type="checkbox"/> PENSION           |              |
| <input type="checkbox"/> G.A.            |  |              |

**INSURANCE INFORMATION (COMPLETE OR ATTACH COPY OF CARD)**

**MEDICAL INSURANCE:** \_\_\_\_\_ **MEDICAID NUMBER:** \_\_\_\_\_

**NAME OF COMPANY:** \_\_\_\_\_ **MEDICAID NUMBER:** \_\_\_\_\_

**NAMES OF INSURED:** \_\_\_\_\_

**POLICY NUMBER:** \_\_\_\_\_

**POLICY EFFECTIVE DATE:** \_\_\_\_\_

*For office use only:*

Case accepted for service coordination: \_\_\_YES / \_\_\_NO

Referred to Council for funding: \_\_\_\_\_

**REASON FOR REFERRAL:**

**MEDICAL INFORMATION:**

**DATE OF LAST PHYSICAL:**

**EXISTING MEDICAL INFORMATION:**

**CURRENT MEDICATION:**

**MENTAL HEALTH DIAGNOSIS (if available):**

**FAMILY HISTORY:**

**FAMILY INTERACTION PATTERNS:**

**EDUCATION INFORMATION OF CHILDREN IN HOME:**

STUDENTS NAME	NAME OF SCHOOL	CITY/STATE	GRADE

**FORMAL SUPPORTS**

Agencies Involved (Please check all appropriate responses):

- |   |   |
|---|---|
| <input type="checkbox"/> Geauga County Board of DD          | <input type="checkbox"/> Geauga County Public Schools       |
| <input type="checkbox"/> Geauga County Dept. Human Services | <input type="checkbox"/> Geauga County After School Program |
| <input type="checkbox"/> Geauga County Health Dept.         | <input type="checkbox"/> Ohio Dept. of Youth Services       |
| <input type="checkbox"/> Geauga County Juvenile Court       | <input type="checkbox"/> BVR                                |
| <input type="checkbox"/> Catholic Charities                 | <input type="checkbox"/> Ravenwood                          |
| <input type="checkbox"/> Social Security Administration     | <input type="checkbox"/> OTHER:                             |

Please fill in details below:

AGENCY	MOST RECENT CONTACT DATE	CONTACT PERSON	PHONE	MISC. INFO.

**INFORMAL SUPPORTS**

Relatives, Friends, 4-H Club, Church Affiliation, Scouts, Support Groups, Organizations:

ORGANIZATION NAME	NATURE OF RELATIONSHIP	MOST RECENT CONTACT PERSON	CONTACT PERSON	PHONE	MISC. INFO.

**FAMILY PAGE**  
(As Stated by Family)

**FAMILY STRENGTHS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAMILY NEEDS/PRIORITIES:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAMILY CULTURAL CONSIDERATIONS:** \_\_\_\_\_  
\_\_\_\_\_

**DO YOU HAVE ANY SPECIAL FAMILY TRADITIONS THAT YOUR FAMILY PARTICULARLY LIKES TO DO TOGETHER?** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAMILY DREAMS/VISIONS/DESIRES:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**RELEASE OF INFORMATION FORM SIGNED?**     \_\_\_ YES     \_\_\_ NO

\_\_\_\_\_  
**PARENT SIGNATURE**

\_\_\_\_\_  
**PARENT SIGNATURE**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**DATE**

**Parents are invited to attend the meeting and can bring a support person.**

**GEAUGA COUNTY FAMILY FIRST COUNCIL**  
**12480 Ravenwood Dr.**  
**Chardon, OH 44024**

**RELEASE OF INFORMATION**

The undersigned, having requested services from the Geauga County Family First Council, do hereby give our consent to the agencies listed below releasing information to the Council for use in preparing and implementing an individual family service plan.

The family members who are covered by this Release are:

1. \_\_\_\_\_ DOB: \_\_\_\_\_
2. \_\_\_\_\_ DOB: \_\_\_\_\_
3. \_\_\_\_\_ DOB: \_\_\_\_\_
4. \_\_\_\_\_ DOB: \_\_\_\_\_
5. \_\_\_\_\_ DOB: \_\_\_\_\_
6. \_\_\_\_\_ DOB: \_\_\_\_\_

**The agencies that are authorized to release information are:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

\_\_\_\_\_  
INITIAL      I authorize the agencies and/or individuals specified above to disclose the information I have initialed below to the other treatment team members specified above. It is understood that the information is requested to assist staff of the program in planning services with me and/or in completing an assessment of me. (Initial information to be released.)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Psycho-social History | <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Psychiatric Evaluation     |
| <input type="checkbox"/> Medical Evaluation    | <input type="checkbox"/> Medications Prescribed   | <input type="checkbox"/> Discharge Summary          |
| <input type="checkbox"/> Education/Test Rec.   | <input type="checkbox"/> Hospitalization Records  | <input type="checkbox"/> Treatment Notes            |
| <input type="checkbox"/> Ind./Family Ser. Plan | <input type="checkbox"/> Lab Rpts./X-rays         | <input type="checkbox"/> Family First Council Rpts. |
| <input type="checkbox"/> DHS Case Plan         | <input type="checkbox"/> Probation Reports        | <input type="checkbox"/> Other (specify _____)      |

I fully understand that my records are protected under federal and state confidentiality regulations and cannot be released or disclosed without my written permission. I understand the reason(s) the information indicated above is being requested.

I fully understand that I may revoke this consent at any time. However, any information shared prior to such a revocation of consent falls within the bounds of this release.

**GEAUGA COUNTY FAMILY COUNCIL  
12480 Ravenwood Dr.  
Chardon, OH 44024**

**RELEASE OF INFORMATION**

Initial only one of the following:

\_\_\_\_\_ This consent, unless revoked earlier, expires on my formal termination from services or ninety (90) days after signing of the Release, whichever occurs first.

\_\_\_\_\_ I agree for this Release to be expanded to one hundred eighty (180) days or the end of my involvement with services, whichever occurs first.

Executed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

Signatures:

Client: \_\_\_\_\_ Parent/Guardian (Circle): \_\_\_\_\_

Client: \_\_\_\_\_ Parent/Guardian (Circle): \_\_\_\_\_

Staff Person: \_\_\_\_\_ Guardian Relationship: \_\_\_\_\_

Agency: \_\_\_\_\_

Witness: \_\_\_\_\_

**NOTICE TO ALL DRUG AND ALCOHOL CLIENTS:** 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 permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42CFR 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 information to criminally investigate or prosecute any alcohol or drug abuse client.