Potter County CASSP

Child & Adolescent Service System Program

CASSP Referral Form

I. Consumer Information:

_____ _____ _____ _____

Consumer Name Age Gender D.O.B.

_____ _____ _____ _____ _____

Address County S.S.#

_____ _____

Township

_____ _____ _____

School School District Grade

Does the consumer have insurance? ☐ Yes ☐ No If yes, indicate if the insurance is ☐ Private ☐ Public

MA #: _____

Mother: (please select) ☐ Birth ☐ Step ☐ Foster ☐ Adoptive ☐ Other Primary Caregiver

Name: _____ _____ Phone: _____

Address: _____ City:_____ State: _____ Zip: _____

Father: (please select) ☐ Birth ☐ Step ☐ Foster ☐ Adoptive ☐ Other Primary Caregiver

Name: _____ Phone: _____

Address: _____ City:_____ State: _____ Zip: _____

Circumstances leading to CASSP referral? _____

_____

_____

Referral Source Name: _____ Phone number: _____

II. Physical and Behavioral/Mental Health Information:

_____ _____

Primary Care Physician Psychiatrist

Please mail completed referral form along with attached release to Potter County Human Services CASSP Coordinator, Christy Lineman BA at P.O. Box 241, North St. Roulette, PA 16746.

Potter County CASSP

Consent to Release Confidential Information

I hereby authorize Potter County CASSP and the following organizations as marked to release information to and receive information from (Please mark boxes for ALL agencies involved):

	Potter County Mental Health		Northern Potter School District
	Potter County Intellectual Disabilities		Oswayo Valley School District
	Potter County Children and Youth		Concern Counseling
	Potter County Drug and Alcohol		Beacon Light Behavioral Health
	Potter County Youth Probation		Dickinson Center, Inc.
	Potter County Early Intervention		Guidance Center
	Community Care Behavioral Health		Sagewood
	Intermediate Unit #9		CenClear
	Austin Area School District		UPMC
	Coudersport Area School District		Other: _____
	Galeton Area School District		Other: _____

From the record of _____ _____

Name Birthdate

_____

Address Zip

The following information will be exchanged for the purpose of referral/case coordination (select all that apply):

	Psychiatric / Psychological reports		Social History / Family Information
	Teacher observations / School records		Attendance Data
	Progress Reports		Report Cards
	Medical Reports		Admission / Discharge Reports
	Neurological Reports		Behavior Reports
	IQ test scores, aptitude and achievement tests		Other: _____
	CASSP referral and summary		Other: _____
	Vocational skills assessment		Other: _____

This release is valid for 12 months from the date of signature and may be revoked by notifying the Potter County CASSP Coordinator in writing or witnessed verbally. I understand that treatment, payment, enrollment or eligibility for benefits and services is not subject to signing this release. However, I choose to sign this release voluntarily to receive CASSP Coordination services. I have read this form carefully and understand what it means.

_____

Signature of Minor (age 14 or above) Date

_____

Signature Parent/Guardian Date

_____

Signature of Witness Date

_____

*** Signature of Witness Date

Verbal release of Information (***requires signature for two witnesses): This section is to be used for consumer who are unable to provide a signature. We have witnessed that the consumer understands the nature of this release and has freely given his/her consent.

In accordance with Pennsylvania Regulations: "This information has been disclosed to you from records whose confidentiality is protected by State Law. State regulations limit your right to make any further disclosure of this information without the prior written consent of the person to whom it pertains."