Clinton County Child Intervention Team Release of Information Form

Youth's Full Name: _____ Youth's Date of Birth: _____

Caretaker/Legal Guardian Name(s): _____

Relationship to Youth (*son, daughter, grandchild, etc.*): _____

The purpose of the sharing of this information is to: **Make a referral to the Child Intervention Team (CIT).** I, the undersigned, hereby authorize and consent to the release to share information with the Clinton County Family and Children First Council which includes the Child Intervention Team, and the:

If applicable **Referring Agency**:		**Name**:
Phone:	**Email**:	**Length of Involvement**:

Information to be shared may include (but is not limited to):

❑ **Identifying information:** name, birth date, gender, race, address, email, and telephone number.

❑ Name & contact information for agencies and individuals providing services to the youth/family.

❑ Case Plan docs: Individualized Education Plans (IEP's), Youth/Family Service Plans, Medical Records, Psychological Evaluations, School Records (attendance, grades, etc.), Social History, Treatment/Service History, Transition Plans, Vocational Assessments, and other pertinent personal information regarding the individual named above.

❑ *Service Coordination is partially funded by Clinton County Job and Family Services, Clinton County Juvenile Court, Clinton County Board of Developmental Disabilities and the Mental Health Recovery Board Serving Warren & Clinton Counties (all of whom requests demographic information, income-level, benefits information and diagnosis information).*

I understand that the Referral Release of Information form expires upon closure of my case with CIT and I may cancel this at any time by providing written notice, which includes guardian name, the name of the youth being served and the effective date. Revocation of the release does not include any information, which was shared between the time that the release was signed and the receipt of the written notice to revoke.

I understand that my signing or refusing to sign this consent will not affect public benefits or services for which I am eligible.	

SIGNATURE **Date** **WITNESS** **Date**

Re-Release of information beyond that allowed by this consent is not permitted.

Clinton County Child Intervention Team Service Coordination Referral Form

Youth Information for CIT Referral				
Youth's Name	**D.O.B.**	**S.S. #**	**School/Grade**	**Adopted Y or N**

Race:
☐ Asian ☐ Bi-Racial/Mixed Race ☐ Black/African American ☐ Hispanic ☐ Native Hawaiian/Pacific Islander ☐ Native American/ Alaskan Native
☐ White or Caucasian ☐ Prefer Not to Answer

Ethnicity:
☐ Appalachian
☐ Hispanic/Latino
☐ Other: _____

Gender: ☐ Male ☐ Female ☐ Non-binary/Other _____ ☐ Prefer Not to Answer

Does the youth identify as lesbian, gay, bisexual, or other? ☐ Yes ☐ No ☐ Don't Know ☐ Prefer Not to Answer

Education: ☐ Community School ☐ Alternative School ☐ Home-schooled ☐ Other: _____

Primary Language: ☐English ☐ Spanish ☐ American Sign ☐ Other:_____ Interpreter needed? ☐Yes ☐No

Current Placement Information-Some youth may not be living at home at the time of referral due to a stay in foster care, juvenile detention, psychiatric hospitalization, treatment facility, etc. Please share where the youth is living right now.

Is the youth out of the home currently? **☐No ☐Yes-when were they placed? _____ Please complete below:**

Placement:	Contact:
Address:	Phone: ( )
City: State: Zip:	Email:

Family Information: Who makes up the family?

Guardian Name:	Guardian Name (if applicable):
Relation:	Relation:
Marital Status: Date of Birth:	Marital Status: Date of Birth:
Address:	Address:
City: State: Zip:	City: State: Zip:
Home Phone: Cell:	Home Phone: Cell:
Employer: Work Phone:	Employer: Work Phone:
Email:	Email:
Primary Language: _____ Interpreter needed? Yes No	Primary Language _____ Interpreter needed? Yes No

Other household members:	DOB	Relationship	Adopted?	School	Grade
			Y or N		
			Y or N		

			Y or N		
			Y or N		

Health Information		
☐	Mental Health	**Primary diagnosis**:
☐	Physical Health	Medical condition(s):
☐	***Does the youth have a doctor or clinic they go to for care?*** ☐Yes ☐ No	

Systems Involvement Check the box if the youth is currently involved with these systems or has a need in the following area		
☐	Children Services	History of: ☐ Abuse ☐ Neglect
☐	Developmental Disabilities	Diagnosed Disability: ☐ Eligible for DD Services ☐ Has a DD Waiver ☐ Other: _____
☐	Juvenile Court	Youth has been found: ☐ Unruly ☐ Delinquent ☐ Other Charge: _____ Is the youth on probation? ☐ Yes ☐ No
☐	Special Education	☐504 plan ☐Evaluation Team Report ☐IEP-Individual Education Plan ☐RTI-Response to Intervention
☐	Substance Use Alcohol & Drugs	Primary diagnosis: Substances used:
☐	Job and Family Services	☐Cash or Food Assistance ☐Ohio Means Jobs Employment Programs ☐**Medicaid** If Medicaid, check plan: ☐ Buckeye ☐CareSource ☐Molina ☐Paramount ☐United Healthcare ☐ Other:_____ **Medicaid #:**_____
☐	Other System: (include private insurance here): _____	

The signature below affirms that the above information is true and correct.	
Guardian or Young Adult's Signature:	Date:

Youth and Family Information

1. **How did you hear about CIT? _____**

_____

2. **What do you hope to accomplish? _____**

_____

List the positives/strengths of the youth and family (at school, at home, in community):
List the major challenges/needs of the youth and family (at school, at home, in community):
List any major life events the youth/family has experienced:
Other information you would like us to know?