AUTHORIZATION TO USE AND EXCHANGE INFORMATION

I understand that different agencies provide different services and benefits. Each agency must have specific information to provide services and benefits. By signing this form, I allow agencies to use and exchange certain information about me, including information in an electronic database, so it will be easier for them to work together efficiently to provide or coordinate these services or benefits.

I, _____ am signing this form for
(FULL PRINTED NAME OF AUTHORIZING PERSON OR PERSONS)

_____
(FULL PRINTED NAME OF INDIVIDUAL)

_____
(INDIVIDUAL'S ADDRESS) (INDIVIDUAL'S BIRTH DATE) (INDIVIDUAL'S SSN – OPTIONAL)

My relationship to the individual is: ☐ Self ☐ Parent ☐ Power of Attorney ☐ Guardian ☐ Other Legally Authorized Representative

I want the following confidential information about the individual to be exchanged:

Yes	*No*		*Yes*	*No*		*Yes*	*No*	
☐	☐	Assessment Information	☐	☐	Medical Diagnosis	☐	☐	Educational Records
☐	☐	Financial Information	☐	☐	Mental Health Diagnosis	☐	☐	Psychiatric Records
☐	☐	Benefits/Services Needed, Planned, and/or Received	☐	☐	Medical Records	☐	☐	Criminal Justice Records
			☐	☐	Psychological Records	☐	☐	Employment Records
☐	☐	Substance Abuse Records				☐	☐	All of the above

Other Information (write in): _____

I want **Frederick County Department of Social Services**, 107 North Kent St., Winchester, VA 22601, Attn: _____ and the following entities to be able to use and exchange this information among themselves:

_____
_____
_____
_____

I want this information to be exchanged **ONLY** for the following purposes:
☐ Service Coordination and Treatment Planning ☐ Eligibility Determination
☐ Other: _____

I understand that my records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) 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 automatically expires as described below:

_____
(Date, event or condition upon which this consent will expire)

I further acknowledge that the information to be released as fully explained to me and that this consent is given of my own free will.

Executed this, the _____ day of _____, 20_____.

This consent ☐ includes ☐ does not include information placed on my records after the above date.

_____
(Signature of patient/client)

_____
(Signature of parent/guardian, where required)

_____
(Signature of person authorized to sign in lieu of parent)

NOTE WHERE INFORMATION ACCOMPANIES THIS DISCLOSURE FORM: This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFR 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 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.

Background Information Checklist

Department of Social Services

____ CPS History on Family (anyone in the household)

_____

_____

____ Foster Care/Family Services Case:

_____

____ Eligibility Cases:

_____ Food Stamps

_____ Medicaid

_____ TANF

_____ VIEW

____ Other: _____

School History

- Last school attended: _____ Grade:_____
- Truancy Issues _____
- IEP: _____
- Behavioral Issues

_____

_____

CSB History

- Family Known to the CSB? ____ Youth ____ Parent
- Identified substance abuse issues: _____
- Identified mental health issues: _____
- On Medication? _____
- Therapist: _____

Juvenile Court History

- Past Court involvement –charges and disposition:

_____

_____

- Current charges: _____

_____

- Future Court date: _____

Parent Criminal History:

_____

Service Providers currently working with family or providing services in recent past:

_____

_____

_____

_____

Child and Family Team Participants Checklist

Child: _____
Mother: _____
Father: _____
Other Family Members or Supportive Individuals: _____

Team Meeting Facilitator: _____
CSA Coordinator: _____
Prevention Case Manager: _____

DSS:
- Social Work Case Manager: _____
- In-Home Worker: _____
- VIEW/TANF Self-Sufficiency Worker: _____
- Eligibility Worker: _____
- Other DSS: _____

School:
- Teacher: _____
- Guidance Counselor/Home-School Coordinator: _____
- Other School Personnel: _____

Mental Health:
- Therapist: _____
- Other: _____

Court:
- Probation Officer: _____
- Court Services Supervisor: _____
- Other: _____

Private providers: _____

Legal Representation

Youth:
- GAL: _____
- Defense Attorney: _____
- Prosecuting Attorney; _____

Caretaker;
- Retained: _____
- Court Appointed: _____
- GAL: _____
- Prosecuting Attorney: _____

Appendix D

Frederick County Department of Social Services
Child and Family Team Meeting: An Invitation to Participate

The Frederick County Department of Social Services has begun to implement a Child and Family Team Meeting procedure for children coming into foster care and for children at risk of coming into care. The purpose of the Child and Family Meeting is to bring together the family and other professionals to develop a plan to prevent the need for out-of-home placement or – if already in placement – to identify what it would take to return the child or children home safely. This approach builds on the child's and family's strengths. It is based on a Team Approach which includes family members and other supportive individuals, the child (if old enough), the social work case manager, and private providers of services to the family. It may also include other Social Services workers (Eligibility Worker, Self-Sufficiency Worker, In-Home Worker, CSA Coordinator and CSA Prevention Case Manager), the Court Services Worker, teachers, mental health professionals, plus the *guardian ad litem* and the attorneys representing the family or the department. In addition to identifying the family's strengths and goals, the Child and Family Team identifies the major issues, outlines the information or evaluations needed and addresses the barriers to success.

The outcome of the meeting is a written plan which becomes the basis for the services to be provided throughout future management of the case. The services and goals are clearly stated and shared with all parties involved including the family, service providers, social workers, court workers, school personnel and the Court. The written plan becomes the basis of the family service plans developed by providers of services. Progress towards the identified goals will form the basis of future reports to the Court. The written plan (with an addendum as to specific costs associated with the services) becomes the basis of the request for funding.

All parties who are to participate in the Child and Family Team Meeting will receive a blank copy of the report form in advance of the meeting. We request that you complete it to the best of your knowledge and bring it with you on the day of the conference. If you do not have in-put for a particular question, simply leave that item blank. If you have been sent this form and cannot attend the Family Team Meeting, we will still like your input. Please complete the form and fax it to the attention of the Social Work Case Manager at 540-535-2146. At the Family Meeting we will discuss each section of the form and develop a Care Plan based on the in-put of all participants.

The use of the Family Team is not a one-time event but an on-going process throughout the life of the case. It is a process whereby all parties can stay informed regarding the progress of the family to prevent placement or to have their child or children returned to their care. The Family Team also identifies the plan should progress not be made towards the goal of return home. (If return home cannot be accomplished safely within a reasonable amount of time, the goal will shift to provide for a permanent placement of the child or children elsewhere.) The participants in the Child and Family Team will be asked to reconvene periodically as circumstances in the case change and the Care Plan evolves to meet the needs of the child and family.

Frederick County Department of Social Services
Child and Family Team
Initial Conference

Child: _____ (DOB: _____)
Child: _____ (DOB: _____)
Child: _____ (DOB: _____)

Parents: Mother: _____
Address: _____
_____

Father: _____ (paternity established? ____)
Address: _____
_____

Current Charge(s): _____
Date of Hearing: _____

Past charge and disposition: _____
_____

Truancy Issues:_____
_____

Child Protective Services Involvement:
_____
_____

Date child came into care: _____

Reason child came into care:
_____

Date of Conference: _____

In attendance:
_____
_____
_____
_____
_____
_____
_____

Invited but not in attendance: _____
_____

Youth's Strengths or Interests: _____

Parent's Strengths:

Formal Assessment(s) Needed:

Child_____

Parent: _____

Extended Family and Naturalistic Support:

Funding Source(s):

_____

Lead Agency / Person responsible for monitoring and reporting progress:

Alternative plan if above services are not successful:

Major Issues:

☐ Child Safety Issues:

☐ Not an issue at this time
☐ Issue: _____

_____
_____

Action Plan to Protect Child: _____
_____
_____

☐ Predictable crisis in family life:
☐ Not an issue at this time
☐ Predictable crisis Action Plan
1)
2)
3)

☐ Other major issues:

_____
_____
_____
_____
_____
_____

The Family Team Meeting Care Plan (See Appendix ____) will identify need(s), ways to meet needs, Plan of Action/Services, Challenges and person(s) responsible and outcome(s) sought.

The Care Plan will be written by the designated recorder and signed by the Child and Family Team participants.

Specific recommendations to the Court:

_____
_____
_____
_____
_____
_____
_____
_____

_____ This Team Meeting served at the FAPT pursuant to policies of the Frederick County CPMT effective August 1, 2008.

Final written plan must be signed and dated by parent/ caretaker.

Appendix F

Family Team Meeting Care Plan

☐ Initial Plan ☐ Review

Family Name: _____ Case Manager: _____ Facilitator: _____ Date: _____

Vision Statement: _____

Need(s)	Ways to meet needs	Plan of Action/Services	Challenges/Barriers	Person(s) Responsible	Outcome
1.					Date of Review: Accomplished: _____ Did not complete: _____ Change: _____ Still in Progress: _____
Outcome:					
2.					Date of Review: Accomplished: _____ Did not complete: _____ Change: _____ Still in Progress: _____
Outcome:					

3.					Date of Review: Accomplished: _____ Did not complete: _____ Change: _____ Still in Progress: _____
Outcome:					

4.					Date of Review: Accomplished: _____ Did not complete: _____ Change: _____ Still in Progress: _____
Outcome:					

5.					Date of Review: Accomplished: _____ Did not complete: _____ Change: _____ Still in Progress: _____
Outcome:					

Date of next Family Team Meeting: _____

Signatures:

	Name	**Signature**	**Date**
Youth			
Parent/Caretaker			
Case Manager			
School			
Court Services			
Mental Health			
Facilitator			
CSA Coordinator			
Foster Care/CPS Supervisor			
Other			

Appendix G

Frederick County Department of Social Services
Strengths Discovery

This is an informal meeting with the youth and family to get acquainted and hear their story. This is not a formal meeting or assessment, but rather an opportunity to explore cultural and traditional norms, values, strengths, and needs and identify any potential informal supports. You should have this time together to frame the family's vision statement.

Tell me more about your current situation?

_____
_____
_____
_____

What is your happiest memory with your family?

_____
_____
_____
_____

What supports do you think you need to better assist you and your family?

_____
_____
_____
_____

It seems as if you have coped with this situation for quite some time. Who have you relied on for assistance?

_____
_____
_____
_____

On a good day, when things seem to be going well, what are you most pleased or proud of about your family?

_____
_____
_____
_____

Do you have any supportive family members, friends, or neighbors in the area?

_____
_____
_____
_____

Has anyone from your child's school been particularly helpful to you?

_____
_____
_____
_____

Do you have a support system at church/faith-based organization? Would you like to fine one?

_____
_____
_____
_____

What kinds of activities do you and your child do together? (If none) What kinds of activities do you think you would enjoy doing with your child?

_____
_____
_____
_____

Vision Statement:
Finish this statement: "Life will be better when …"

_____
_____
_____
_____

Family Strengths:

1. _____
2. _____
3. _____
4. _____
5. _____

Child's Strengths:

1. _____
2. _____
3. _____
4. _____
5. _____

People who might attend my Family Team Conference (Name and contact information):

_____
_____
_____
_____

Appendix H

Informal Community and Family Support

ABBA
Access Independence
Alcoholics Anonymous/Alanon/Alateen
American Red Cross
Apple Country Head Start
ARC of Northern Shenandoah Valley
Big Brothers/Big Sisters
Blue Ridge Hospice
Blue Ridge Legal Aide
Boy Scouts of America-Shenandoah Area Council
Boys & Girls Club of Northern Shenandoah Valley
C-CAP
Child Development Center
Child Parent Center
Churches
CLEAN, Inc.
Community-Housing Program
Concern Hotline, Inc.
Consumer Credit Counseling Service
Council on Alcoholism-Lord Fairfax House
Edgehill Recovery Center
Faith in Action
Food Pantries
Family
Frederick County Parks & Recreation
Free Medical Clinic
Friends
Fremont Street Nursery
Girl Scouts of Shawnee Council, Inc.
Goodwill Winchester
Habitat for Humanity
Handley Regional Library
Healthy Families
Help with Housing
Highland Memorial Presbyterian Church Food Pantry
Infant & Toddler Connection of Shenandoah Valley
Knights of Columbus
Kitchen of Hope-Market Street UMC
Literacy Volunteers-Winchester Area
Lions' & Lioness' Clubs
Lord Fairfax Community College
Logisticare

Lutheran Family Services Mentorship Program
March of Dimes Birth Defects Foundation
Narcotics Anonymous
National Alliance for the Mentally Ill
Northern Shenandoah Valley Workforce Center
Northwestern Community Services
NW Works, Inc.
Open Door Food Pantry
Regional GED Testing Center
Salvation Army
School Clubs
Share the Cheer Foundation
Shelter for Abused Women
Special Need Registry
Sports Teams
Telamon Corporation
Toys for Tots Program
Union Rescue Mission of Winchester
United Way of Northern Shenandoah Valley
Valley Health Line
Virginia Autism Resource Center
Virginia Cooperative Extension
Virginia Department for the Deaf and Hard of Hearing
Virginia Department of Rehabilitative Services
Virginia Employment Commission
Virginia Office for Protection & Advocacy
Volunteer Emergency Families for Children
Volunteer Income Tax Assistance
Winchester Day Nursery Inc.
Winchester/Frederick County Health Department
Winchester/Frederick County Child Advocacy Center
Winchester Migrant Head Start
Winchester Parks & Recreation
Winchester Union Rescue Mission
Youth Development Center

<u>Support Group</u>
Differently Abled Club
Family's Anonymous
Friends Who Care
New Mom's Support Group
Prison Fellowship

Appendix I

Budget Request Form

The following form will be used for all Budget Requests. It will be used by the Case Aide to establish the case in Thomas Brothers and to generate all Purchase Orders and Case Actions. The Case Manager will fill out service provider, frequency, beginning and ending dates. Case Aid will complete unit cost, total cost and funding category.

Child's Name: _____
Case Manger: _____
CSA Approval: _____ Date: _____

Service to be Provided	Provider	Frequency	Beginning/Ending Dates	Unit Cost	Total Cost	Funding Category IVE; CSA

Referral Source _____
Case Manager _____
Agency/Organization _____
Phone Number _____

Date Referral Completed
Date Consent to Exchange Information Form Signed _____
Date Referral Letter Received _____
Date Parent Notification/Invitation Letter Sent

1. CHILD'S INFORMATION

Name of Client: Sex: ( ) Male ( ) Female
Address:
Social Security Number: _____ **Has Child been adopted**? ( ) Yes ( ) No
Age: _____ **Race**: _____ **D.O.B**: _____ **Hispanic**? ( ) Yes ( ) No
School: _____ **Grade**:
Who has legal custody of child? _____ **Identified Disability**: (DSM IV Diagnosis)
Any psychotropic medications? _____ **Is child on Autism Spectrum?** _____

2. FAMILY INFORMATION [complete if not included above]

Child's Mother: _____	**DOB**:	**In Household**?
		( ) Yes ( ) No
Phone:_____ **SS#:** _____	**Hispanic**?	**Race**
	( ) Yes ( ) No	
Child's Father: _____	**DOB**:	**In Household**?
		( ) Yes ( ) No
Phone: _____ **SS#:** _____	**Hispanic**?	**Race**
	( ) Yes ( ) No	

Parent's Marital Status at the time of Child's birth? **Married** ___ **Divorced** _____ **Separated** ___
Caregiver's relationship to the Child _____

Child's Siblings:	**Hispanic**?	**Race**	**DOB**	**In Household**
	( ) Y ( ) N			( ) Yes ( ) No
	( ) Y ( ) N			( ) Yes ( ) No

3. SIGNIFICANT PEOPLE IN CHILD'S LIFE

Name:	**Hispanic**?	**Race**	**DOB**	**In Household**
	( ) Y ( ) N			( ) Yes ( ) No

4. PLACEMENT INFORMATION

Name:
Address: _____ **Date of Entry**: **Date of Exit**
_____

Type of Removal: **Voluntary** _____ **Emergency** __ _____ **Court Ordered** _____
Court Dates and Type of Hearing: ( ) **Initial** _____ ( ) **Review** _____ ( ) **Permanency** _____
Court Hearings: Past and Future Dates

Immediate Goal of the Child: Does the child have Medicaid?:_____
Future Goal of the Child: Is this child eligible for IV-E? _____
Estimated Plan Completion Date:

Mandate type: ☐ Foster Care Prevention; ☐ DSS Non-Custodial Agreement; ☐ DSS Custody; ☐ CHINS Prevention; ☐ CHINS CSA Parent Agreement; ☐ CHINS Custody; ☐ Court-ordered Truancy; ☐ Court-ordered Delinquency; ☐ Special Ed Prevention; ☐ Special Ed; ☐ Non-Mandated

Appendix K

Team Meeting Observation Form

Client ID_____ **Date**_____ **Care Center: North Central South**

Initial Meeting_____ **UR Meeting**_____ **Transition Meeting**_____

Care Coordinator_____ **Care Manager**_____

Location of Meeting_____ **Initial Entry Date**_____

Observer_____ **Meeting Start Time**_____ **End Time**_____

Team Members Present (First name only)	**Role**	**Agency/Family/Community**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Life Domain Areas Addressed In Plan of Core
(Check all those discussed at meeting)

1. **Cultural** _____
2. **Education** _____
3. **Family** _____
4. **Legal** _____
5. **Medical/Self Care** _____
6. **Mental Health** _____
7. **Residential** _____
8. **Safety** _____
9. **Social/Recreational** _____
10. **Substance Abuse** _____
11. **Vocational** _____

COMMUNITY			
1. Information about resources/intervention in the area is offered to the team.	**Y**	**N**	
2. Plan of care includes at least one public and/or private community service/resource.	**Y**	**N**	
3. Plan of care includes at least one informal resource.	**Y**	**N**	
4. When residential placement is discussed, team chooses community placements for child(ren) rather than out-of-community placements, whenever possible.	**Y**	**N**	**NA**
5. Individuals (non-professionals important to the family are present at the meeting.	**Y**	**N**	
INDIVIDUALIZED			
6. If an initial plan of care meeting, the parent is asked what treatments or interventions he/she felt worked/didn't work prior to LPS.	**Y**	**N**	**NA**
7. Care Coordinator advocates for services and resources for the family (e.g., identified and argues for necessary services).	**Y**	**N**	
8. All services needed by family are included in plan (i.e., no needed services were not offered).	**Y**	**N**	
9. Barriers to services or resources/interventions are identified and solutions discussed.	**Y**	**N**	**NA**
10. The steps needed to implement the plan of care are clearly specified by the team.	**Y**	**N**	
11. Plan of care that includes life domain(s) goals, objective, and resources/interventions is discussed (or written).	**Y**	**N**	
12. Plan of care goals, objective, or interventions are based on family/child strengths.	**Y**	**N**	**NA**
13. Safety plan/crisis plan developed/reviewed.	**Y**	**N**	**NA**
FAMILY			
14. Convenient arrangements for family's presence at meeting are made (e.g., location, time, transportation, day care arrangements).	**Y**	**N**	**NA**
15. The parent/child is seated or invited to sit where he/she can be included in the discussion.	**Y**	**N**	**NA**
16. Family members are treated in a courteous fashion at all times.	**Y**	**N**	**NA**
17. The family's perspective is presented to professionals from other agencies.	**Y**	**N**	**NA**
18. The family is asked what goals they would like to work on.	**Y**	**N**	**NA**
19. The parent is asked about the types or services or resources/interventions he/she would prefer for his/her family.	**Y**	**N**	**NA**
20. Family members are involved in designing the plan of care.	**Y**	**N**	**NA**
21. In the plan of care, the family and team members are assigned (or asked) tasks and responsibilities that promote the family's independence (e.g., accessing resources on own, budgeting, maintaining housing).	**Y**	**N**	**NA**

22. The team plans to keep the family intact or to reunite the family.	**Y**	**N**	**NA**
23. Family members voice agreements/disagreement with plan of care.	**Y**	**N**	**NA**
INTERAGENCY/COLLABORATION			
24. Staff from other agencies who care about or provide resources/interventions to the family are present at the meeting.	**Y**	**N**	
25. Staff from other facilities or agencies (if present) have an opportunity to provide input.	**Y**	**N**	**NA**
26. Informal supports (if present) have an opportunity to provide input.	**Y**	**N**	**NA**
27. Problems that can develop in an interagency team (e.g., turn problems, challenges to authority) are not evident or are resolved.	**Y**	**N**	**NA**
28. Staff from other agencies described support resources/interventions available in the community.	**Y**	**N**	**NA**
29. Statement(s) made by a staff member or an informal support indicate that contact/communication with another team member occurred between meetings.	**Y**	**N**	**NA**
30. Availability of alternative funding sources is discussed before flexible funds are committed.	**Y**	**N**	**NA**
UNCONDITIONAL CARE (*If one NA, all NA)			
31. Termination of a network services is discussed because of the multiplicity or severity of the child.	**Y**	**N**	**NA**
32. Termination of other services is discussed because of the multiplicity or severity of the child's/families behavioral problems.	**Y**	**N**	**NA**
33. For severe behavior challenges (e.g., gangs, drugs), discussion focuses on safety plans/crisis plans (e.g., services and staff to be provided) rather than termination.	**Y**	**N**	**NA**
OUTCOMES			
34. The plan of care goals are discussed in objective, measurable terms.	**Y**	**N**	**NA**
35. The criteria for ending LPS involvement are discussed.*	**Y**	**N**	**NA**
36. Objective or verifiable information on child and parent functioning is used as outcome date.	**Y**	**N**	
MANAGEMENT			
37. Key participations are invited to the meeting (i.e., family members, case worker, teacher, therapist, others identified by the family.)	**Y**	**N**	**NA**
38. Current information about the family (e.g., social history, behavioral and emotional status) is gathered prior to the meeting and shared at meeting (or beforehand).	**Y**	**N**	
39. All meeting participants introduce themselves (if applicable) or are introduced.	**Y**	**N**	**NA**
40. The family is informed that they may be observed during the meeting.	**Y**	**N**	**NA**

41. Plan of care is agreed on by all present at the meeting.	**Y**	**N**	
CARE COORDINATOR			
42. Care Coordinator presents the family vision of “Life with be better when…	**Y**	**N**	**NA**
43. Care Coordinator reviews goals, objective, interventions, and/or progress of plan of care.	**Y**	**N**	**NA**
44. Care Coordinator directs (or redirects) team to discuss family/child strengths.	**Y**	**N**	
45. Care Coordinator directs (or redirects) team to revise/update plan of care.	**Y**	**N**	
46. Care Coordinator summarizes content of the meeting at the conclusion of the meeting.	**Y**	**N**	
47. Care Coordinator sets next meeting date/time.	**Y**	**N**	**NA**