Archuleta County Collaborative Management Program

REFERRAL FORM

Please submit the Referral Form AND Signed Authorization to Share Information Form for review.

REFERRAL INFORMATION
Date:
Person Making the Referral:
Phone:
Email Address:
Name of Organization:

CHILD/YOUTH INFORMATION
Name:
Date of Birth:
School:

FAMILY INFORMATION
Name of Parent/Guardian(s):
Phone Number(s):
Home Address:
List Siblings: (Name, DOB, School):
Other Supports/People in the Home:

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WHAT SYSTEMS IS THE CHILD/YOUTH INVOLVED IN? *Check all that apply.*	
☐ Archuleta Dept. of Human Services	☐ Archuleta County School District (50JT)
☐ Pagosa Community Initiative	☐ San Juan Mountain School
☐ Archuleta Public Health Department	☐ Pagosa Peak Open School
☐ Pagosa Springs Medical Center	☐ Goal Academy
☐ Axis Health System	☐ Wings Early Childhood Center
☐ Colorado Division of Youth Services	☐ San Juan Boces
☐ Colorado Youth Detention Continuum (CYDC)	☐ Bridges Program
☐ High Country Counseling	☐ BETA Program
☐ Mountain Health and Psychiatric Services	☐ Archuleta Housing Authority
☐ Authentic Solutions	☐ (Other)___________________________
☐ Pagosa Medical Group	☐ (Other)___________________________
☐ Probation	☐ (Other)___________________________

REASON FOR REFERRAL/BIGGEST CHALLENGES: *Please explain concerns for this child/youth and/or family that will be discussed during family meeting.*

CHILD/YOUTH & FAMILY'S STRENGTHS: *List strengths, including support systems.*

WHAT SYSTEMS/RESOURCES HAVE THE FAMILY OR INDIVIDUALS ALREADY CONNECTED TO OR UTILIZED IN THE PAST?

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AUTHORIZATION TO SHARE INFORMATION

Name of Child/Youth: ____________________________

Date of Birth: __________________________________

Ethnicity of Child/Youth: __________________________

Name of Parent/Guardian: ________________________

As a participant in the Collaborative Management Program (HB1451/ISST), by signing this release I give permission allowing the following agencies share information with one another. Only the information necessary to collaborate more effectively and serve your family better will be shared. We may interact with the following agencies during this process to help create a coordinated plan that will best meet your family's needs. Please mark the agencies that you agree can share information with each other to best serve your family:

- ☐ Archuleta Dept. of Human Services
- ☐ Pagosa Community Initiative
- ☐ Archuleta Public Health Department
- ☐ Pagosa Springs Medical Center
- ☐ Axis Health System
- ☐ Colorado Division of Youth Services
- ☐ Colorado Youth Detention Continuum (CYDC)
- ☐ High Country Counseling
- ☐ Mountain Health and Psychiatric Services
- ☐ Authentic Solutions
- ☐ Pagosa Medical Group
- ☐ Law Enforcement: ____________________
- ☐ Archuleta County School District (50JT)
- ☐ San Juan Mountain School
- ☐ Pagosa Peak Open School
- ☐ Goal Academy
- ☐ Wings Early Childhood Center
- ☐ San Juan Boces
- ☐ Bridges Program
- ☐ BETA Program
- ☐ Archuleta Housing Authority
- ☐ (Other)__________________________
- ☐ (Other)__________________________
- ☐ (Other)__________________________

The purpose of this form is to enable agencies to make appropriate recommendations and allow them to better serve your child/youth/family through coordinated service planning and delivery.

The agencies and providers will share confidential information only in our presence or in situations where they need the information to manage or provide services to the child/youth/family or other person/persons for whom I/we are legally responsible (ward). This may include encrypted emails. This authorization is valid for past, present and future CMP services. This authorization expires one year from the date I/we sign the form, when the sharing of information is no longer needed to manage or provide services to our youth/ward, or when I/we revoke this authorization, whichever is sooner. Any information shared and gathered by this program prior to the expiration or revocation of this release may continue to be used by the program for statistical and program evaluation purposes.

I have read and agree to the following (please initial each paragraph below):

_______ I understand that the following types of information may be shared: information that identifies me/my/our family, my child/youth/ward; records which have information about disabilities, diagnosis, evaluations, or treatment; drug and/or alcohol treatment information; sex offender evaluations and treatment information; work school and social reviews and histories; education records; plans about

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services or benefits, eligibility information; information on finances; placement histories; medical psychiatric and psychological histories; information related to HIV-related care; or legal history. This authorization covers all admissions and/or contact with the above listed agencies and service providers. This authorization allows a free exchange of this information between and among the agencies that you are working with.

_______ I understand that agencies may need to share information among themselves more than once and/or with other staff working for the agencies.

_______ I understand I can revoke this authorization at any time except for information already shared through this authorization. From the date of the revocation forward, agencies and providers will not share information unless it was already lawfully released, or the law allows them to, without my authorization, unless it is for the purpose of program evaluation or compiling statistical data.

By signing this Authorization form, I agree that I have read and understood the information contained in it.

____ Date ________________

Signature of Parent/Guardian (If you are not a parent, please indicate your authority to act for the child. If you are a foster parent, please provide a copy of the court order.)

____ Date _________________

Signature of Youth (as appropriate)

____ Date __________________

Signature for Revocation (as appropriate)

Notice to Recipient: This authorization is specific to the House Bill 1451: Collaborative Management Program.