



**Family Resource Center
Archuleta County Collaborative Management Program**

REFERRAL FORM

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

REFERRAL INFORMATION

Date: _____ Phone: _____

Email Address: _____

Name of Person and Organization Making the Referral: _____

Adult INFORMATION

Name: _____ Phone: _____

Email Address: _____

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

CHILD/YOUTH INFORMATION

Name: _____

Date of Birth: _____ Race/Ethnicity: _____

Number of Family Members: Adults- _____ Children- _____

Gender Identity: _____ Disability Status: _____

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



Family Resource Center
Archuleta County Collaborative Management Program
AUTHORIZATION TO SHARE INFORMATION

Name of Child/Youth: _____ Date of Birth: _____

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 to 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:

- | | |
|--|--|
| <input type="checkbox"/> Pagosa Community Initiative Staff | <input type="checkbox"/> Pagosa Medical Group |
| <input type="checkbox"/> Authentic Solutions | <input type="checkbox"/> San Juan Boces |
| <input type="checkbox"/> HighCountryCounseling | <input type="checkbox"/> Archuleta Dept. of Human Services |
| <input type="checkbox"/> Axis Health | <input type="checkbox"/> Southwest Center of Independence |
| <input type="checkbox"/> BETA Program | <input type="checkbox"/> Forge Martial Arts |
| <input type="checkbox"/> Pagosa Springs Elementary | <input type="checkbox"/> La Plata Family Center Coalition |
| <input type="checkbox"/> Pagosa Springs Middle School | <input type="checkbox"/> Pagosa Outreach |
| <input type="checkbox"/> Pagosa Springs High School | <input type="checkbox"/> Rise above Violence |
| <input type="checkbox"/> Pagosa Peak Open School | <input type="checkbox"/> Hickory Ridge |
| <input type="checkbox"/> San Juan Mountain School | <input type="checkbox"/> Archuleta Housing Authority |
| <input type="checkbox"/> Goal Academy | <input type="checkbox"/> Aspire |
| <input type="checkbox"/> Wings Early Childhood Center | <input type="checkbox"/> Collaborative Management Program |
| <input type="checkbox"/> Seeds of Learning | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Tri County HeadStart | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> San Juan Basin Health | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Pagosa Springs Medical Center | <input type="checkbox"/> Other: _____ |

This release is valid for one year from _____ to _____

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 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)

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