NMCAA Head Start/Early Head Start Mental Health Child/Family Request/Referral/Release

Staff and/or Family may contact the Mental Health Consultant / Therapist anytime with questions, if there are unmet therapy or consultation needs, or for treatment follow-up reports, or for scheduling a planning / goal setting meeting.

Referral Discussions: Teachers discuss classroom referrals w/ ED Coach and informs their FES; FES discusses home referrals w/ Teacher & Manager; CFS discusses with PSC; Collaborative Center and Expansion Teachers discuss w/ CCSC or SC and/or FSS.

Referring Staff: Please complete this form thoroughly. Make sure the Parent/Guardian has properly signed and dated this form.

Mental Health Budget Supports Head Start/Early Head Start families only and we refer via health insurance when possible. GSRP families are referred via health insurance.

NAME OF CHILD / FAMILY; TRANSPORTATION; INSURANCE:

Child/Family's Name:

Child's Date of Birth: **Child's Site Name or EHS Location:**

Does Family Have Reliable Transportation? Yes No

Specific Name of Insurance or Medicaid Type:

SUPPORT REQUESTED: Type of Support Uncertain: Yes No Referral for Parent *Only*? Yes No

Classroom and/or Home Interventions: Classroom Observations / Support *or* Child Observation / Support Home Visits

Office Based: Office-Based Counseling Play Therapy

ASSESSMENTS COMPLETED: DECA P-2: Yes No Clinical e-DECA: Yes No Sensory Measure: Yes No
(Ed Coach Approval Needed)

IEP / IFSP (or in process): Yes No Reason:

Staff may complete or Consultants may Complete: Trauma Checklist: Yes No ACES Questionnaire: Yes No

PARENT / GUARDIAN NAMES, ADDRESSES, AND CONTACT INFORMATION:

Parent / Guardian Name:
First/Last

Address:

Cell: **Email:**

Parent / Guardian Name:
First/Last

Address:

Cell: **Email:**

OTHER CHILDREN ENROLLED (DUAL-ENROLLED) IN NMCAA CHILD DEVELOPMENT PROGRAMS:

Child's Name:
First/Last

Child's Date of Birth: **Child's Site Name, CFS or EHS Location:**

Child's Name:
First/Last

Child's Date of Birth: **Child's Site Name, CFS or EHS Location:**

(Please identify any additional children not enrolled in NMCAA Child Development Programs in the "additional comments" section).

STAFF CONTACT INFORMATION:

Teacher Contacts for: Head Start, Collaborative Centers or Expansion Centers: (Teachers may also be the referring staff.)

Name: **Site Name and Address:**

Telephone: **Cell:** **Email:**

Referring Staff contacts for any of the Child Development program options: Child and Family Specialist (CFS), Family Engagement Specialist (FES), Collaborative Center Services Coordinator (CCSC), Site Coordinator (SC), or Family Services Specialist (FSS):

Name: **Position:**

Telephone: **Cell:** **Email:**

Ed Coach, or EHS – Program Services Coordinator, or Collaborative Center Services Coordinator or Expansion Center Site Coordinator Information:

Name: **Position:**

Telephone: **Cell:** **Email:**

REASON(S) FOR MENTAL HEALTH REQUEST:

Referring Staff Completes the following per family request: Please provide detailed reasons for this Mental Health Request / Referral / Release, including any identified concerns and/or traumas or adverse experiences affecting the child and/or family being referred.

PARENT / GUARDIAN AUTHORIZATION AND AGREEMENT:

Communication and meetings with the Mental Health Consultant/Therapist and/or Head Start or Early Head Start staff working with the family may occur to identify child/family strengths, and areas for growth. This release includes some or all the following: child observations; various therapies and interventions; increasing protective factors and resilience; positive parenting, relationships, and family functioning; coping with traumas; evaluation, assessment, and planning for child/family mental wellness, strengths and needs; healthy social and emotional development; behavioral challenges; and/or sensory needs. When needed, mental health support may include some remote services.
Videotaping may be used to observe interactions and responses to identify strengths for planning. Videos will be deleted.

Staff informs the Mental Health Manager if the referred child/family drops from HS/EHS programming, transitions to another program or discontinues their mental health services. This Request/Referral/Release is effective for the current school year. A new Referral form is required to continue mental health services into a new school year.

PARENT / GUARDIAN SIGNATURE: Date:
(Can be electronic or a physical signature)

Save completed referral to computer; email/scan to Stacey Parent: sparent@nmcaa.net / (231) 313-6755). Attach multiple mh referrals separately. - Do not scan them as one attachment.

Mental Health Consultant/Therapist Contact Information: (Completed by Mental Health Manager)

Name: **Telephone:** **Email:**

INSURANCE PAID: Yes No NMCAA Paying: Up to 10 initial sessions; additional sessions need approval.

Staff and family may offer additional family Information, including elementary-aged children who are in the home.