

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.

NAME OF CHILD / FAMILY; TRANSPORTATION; INSURANCE:

Child/Family's Name: _____
First Last

Child's Date of Birth: _____ Child's Site/Teacher Name or EHS Location: _____

Does Family Have Reliable Transportation? Yes No Specific Name of Insurance or Medicaid Type: _____

STAFF PROVIDES DETAILED REASONS FOR MENTAL HEALTH REQUEST/REFERRAL/RELEASE:

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 virtual services.

Videotaping may be used to observe interactions and responses to identify strengths for planning. Videos will be deleted.

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: (Can be electronic or a physical signature)

_____ Date: _____

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

Classroom Support: Whole Classroom Observation Individual Child Observation / Support: Home Support: Home Visits

Office Based Counseling: Therapy or Parent Coaching: Child/Play Therapy Virtual Therapy

Parent / Guardian Names:

_____ _____
First Last

Address:

Cell: _____ Email: _____

Parent / Guardian Names:

_____ _____
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: _____

Additional family information, including elementary-aged children who are in the home.

E Deca completed and strategy planning facilitated by staff: DECA P-2: Yes No Clinical e-DECA: Yes No

E Deca/Clinical Strategies reviewed by Teacher/Ed Coach? Yes No **Noni resources Utilized:** Yes No

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

Staff may complete: Trauma Checklist OR ACES Questionnaire: Yes No

Referring Staff Titles: Child and Family Specialist (CFS), Family Engagement Specialist (FES), Collaborative Center Services Coordinator (CCSC), Site Coordinator (SC), Family Services Specialist (FSS) or Family Center Specialist (FCS):

Name: _____ **Position:** _____

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

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

Name: _____ **Site Name and Address:** _____

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

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

Name: _____ **Position:** _____

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

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 Teachers w/ CCSC or FSS; FCS discusses with their Site Coordinator (SC).

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.

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. A new referral is required for each program year.

Save completed referral to computer; email/scan to Stacey Parent: sparent@nmcaa.net / (231) 313-6755). **Each mh referral must be scanned separately, not as one attachment.**

MH Manager Completes – Therapist Name: _____ **Phone:** _____ **Email:** _____

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