**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. 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 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:**

***(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 meeting with the Mental Health Consultant/Therapist and/or Head Start or Early Head Start staff working with the family to celebrate child/family strengths and growth and for treatment goals in the following areas: child observations; various therapies and interventions; increasing protective factors and resilience; positive parenting, relationships and family functioning; working on overcoming 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 will be through remote (virtual) means. **Are you willing to have sessions video-taped for identifying strengths and planning?** **[ ]**  **Yes** [ ]  **No Videos will be deleted.**

***Staff will inform 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: (Can be electronic or a physical signature)**

 Date:

**Save completed referral to computer; email 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.**