



**DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH & THEIR FAMILIES  
DIVISION OF PREVENTION & BEHAVIORAL HEALTH SERVICES INTAKE  
SERVICES**

**1825 Faulkland Road Wilmington, DE 19805 (302) 633-2571 or (302) 633-2591**

**Please fill out this form as completely as possible and call if you need assistance.**

**Fax this form to (302) 622-4475**

Date:	Client Name:	DOB:	
Gender: <input type="checkbox"/> M <input type="checkbox"/> F		Race:	Ethnicity:
Child's Current Address:			
City/Town:	County:	State:	Zip:
Education Classification:	School:	Grade:	
With whom does child live?		Relation to child:	

**Mother Name :** \_\_\_\_\_ **Address:** \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_ Employer: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_

**Father Name:** \_\_\_\_\_ **Address:** \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_ Employment: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_

**Custodian Name:** \_\_\_\_\_ **Address:** \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_ Employment: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_

Current MEDICAID (Delaware Physicians Care, Unison, Diamond State Partners)?  Y  N  Unknown

Private Insurance?:  Y  N Name of company: \_\_\_\_\_

Is insurance exhausted?  Yes  No  Unknown

If insurance was denied, was it appealed?  Yes  No  Unknown

If you have copies of letters from the insurance company or appeal, please attach.

Court Involvement: Charges pending? :  Y  N Please attach available court orders.

**When legible recent treatment records and assessments are attached, "see attached" is an acceptable response to questions below.**

Most Recent Previous Treatment history:

Mental Health or Substance Abuse Treatment Provider:	Outpatient, day, residential, or hospital?	Admit Date	Discharge date

**Current Therapist**, Agency, number of sessions in last month

What child mental health or substance abuse problems do you want treated ?

1.

2.

3.

4.

Has the child threatened to hurt him/her self or actually injured him/her self? Has the child put him/her self in danger? Is there a family history of self-harm?

Describe past and present aggressive or violent behavior in the school, at home, and/or in the community:

Describe any use of drugs or alcohol by child and family.

Has the child been physically or sexually abused?

Has the child been involved in or witnessed serious violence or life threatening situations?

List all serious medical problems and significant disabilities.

Who is the child's family doctor?  
List other doctors the child sees regularly and reason:

Phone if known:

Current medicine	dose	Doctor who prescribed

What challenges has the family faced?

What are the child and family's strengths and interests?

If known, Most Recent Diagnosis:

By Whom:

Date:

Axis I:

Axis II:

Axis III:

Print Name of Referral Agent \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to Child \_\_\_\_\_

Organization/Agency \_\_\_\_\_ Position \_\_\_\_\_

Referral Agent Signature \_\_\_\_\_

**Parent /Guardian: I give permission to release the information in this referral to DPBHS, and grant permission for DPBHS to: 1. contact parties listed in this referral to obtain further information as required, 2. share this information with the Medicaid office if they believe that my child may be eligible for disabled child coverage, and 3. share this information with authorized service providers if my child is eligible for DPBHS services.**

Parent/Guardian Signature \_\_\_\_\_

(required for consideration of the application)

DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH  
AND THEIR FAMILIES  
Delaware Youth and Family Center  
1825 Faulkland Road, Wilmington, DE 19805



**CONSENT FOR THE RELEASE OF  
CONFIDENTIAL ALCOHOL OR DRUG TREATMENT INFORMATION**

I, \_\_\_\_\_, authorize  
(Print name of youth)

Please check appropriate box:

- Division of Family Services (DFS)
- Division of Youth Rehabilitation (YRS)
- Parent / Guardian
- Family Court
- Superior Court

- Department of Education (DOE)
- Multi Disciplinary Team (MDT)
- Deputy Attorney General's Office (DAG)
- Public Defender (PD) / Private Attorney (PA)
- Other (Please specify): \_\_\_\_\_

To disclose  To receive from the Division of Prevention and Behavioral Health Services the following information:

All information pertinent to substance abuse, including verbal communication, treatment progress and assessment, drug screen reports, and discharge summary.

The purpose of the disclosure authorized herein is to: Assist in completion of Prevention and Behavioral Health Services evaluation(s), treatment recommendations, and / or placement.

I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent, unless otherwise provided for in the regulations. I have the right to receive a copy of this form after completing it. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event, this consent expires automatically as follows:

**THIS AUTHORIZATION WILL EXPIRE SIX (6) MONTHS FROM DATE OF SIGNATURE**

\_\_\_\_\_  
Signature of Youth  
(mandatory for 14 years and older)

\_\_\_\_\_  
Print Name of Youth

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian  
(mandatory if client under 14 years old)

\_\_\_\_\_  
Print Name of Parent or Guardian

\_\_\_\_\_  
Date

**PROHIBITION ON REDISCLOSURE OF INFORMATION CONCERNING CLIENT IN  
ALCOHOL OR DRUG ABUSE TREATMENT**

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with consent of such a client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Revised: 8/11/09



**CONSENT FOR RELEASE OF CONFIDENTIAL  
MENTAL HEALTH INFORMATION  
DIVISION OF PREVENTION & BEHAVIORAL HEALTH SERVICES**

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I, (Parent/Guardian/Custodian/DFS) \_\_\_\_\_ hereby authorize the Division of Prevention and Behavioral Health Services (DPBHS) to Release Verbal/Written Information to and to receive verbal and written information from:

Agency name or school: \_\_\_\_\_

Name of contact person at agency/school (if known): \_\_\_\_\_

**Verbal and written information to be released by DPBHS: (Check all items that apply.)**

- Admission / Discharge Summaries (DPBHS services for past 2 years)
- Service Admission Form (includes Demographics, CSM Service Plan, DPBHS Treatment History, Medication History, Risk Factors)
- DPBHS Psychosocial Evaluation       DPBHS Psychological Evaluation       DPBHS Psychiatric Evaluation
- Educational Records       Treatment Progress/Summary
- Most recent physical exam (not to include pregnancy, STD, HIV information)
- Other: \_\_\_\_\_

**The purpose of this information disclosure by DPBHS is to: (Check all items that apply.)**

- Make a referral/provide treatment by the clinical treatment organization or person listed above
- Assist in the completion of PBHS Evaluation(s)
- Provide clinical information to organization or person named above

**Verbal and written information to be released to DPBHS: (Check all items that apply.)**

- Initial Evaluation       Comprehensive Treatment Plan       Discharge Summary
- Treatment Progress Summary       Physical Examination       Speech and Language Evaluation
- Neurological Evaluation       Medication History       Psychiatric Evaluation
- Most recent educational records including educational testing and school psychological, IEP/IPRD documents, school attendance and behavioral/disciplinary records
- Other \_\_\_\_\_

**The purpose of this information disclosure by the agency/school named above is to: (Check all items that apply.)**

- Enable PBHS to Plan, Monitor, Authorize Payment, Coordinate Care with Treatment Provider
- Enable PBHS to use the educational material in planning treatment
- Enable PBHS to collaborate with the school in planning and providing services
- Assist in the completion of PBHS Evaluation(s)

I understand that this form can not be used to release information about drug and alcohol treatment, pregnancy, HIV status, and sexually transmitted diseases.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present it to the Director of Quality Improvement in the Division of Prevention of Behavioral Health Services. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this release in order to be assured treatment. I understand that I may inspect or copy the information used or disclosed as provided in 45 C.F.R. 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and that the information may not be protected by federal confidentiality rules. If I have any questions about the disclosure of my health information, I can contact the Director of Quality Improvement, Division of Prevention and Behavioral Health Services.

This Release of Information demonstrates compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 C.F.R. pts. 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Once the requested Personal Health Information (PHI) is disclosed, the recipient may re-disclose it, therefore the privacy regulations may no longer protect it.

**This authorization is valid for one year from the signature date unless revoked.**

\_\_\_\_\_  
Parent, Guardian, Custodian, DFS Signature (Circle one)

\_\_\_\_\_  
Print Name/Date

\_\_\_\_\_  
DSCYF Representative Signature

\_\_\_\_\_  
Print Name/Date

**STATE OF DELAWARE  
EARLY AND PERIODIC SCREENING, DIAGNOSIS, TREATMENT (EPSDT)  
MENTAL HEALTH AND SUBSTANCE ABUSE SCREEN**

Child's Name \_\_\_\_\_ DOB \_\_\_\_\_

Date of Screen \_\_\_\_\_ Name of Screener \_\_\_\_\_

Title \_\_\_\_\_ Agency \_\_\_\_\_

Source of Information \_\_\_\_\_ Relationship to Child \_\_\_\_\_

**The purpose of this screen is to identify children who may be in need of help with behavioral or emotional problems and/or who have risk factors associated with the development of behavioral or emotional problems. Not all children identified through this screen may require ongoing mental health treatment, however, if a child is identified, a referral for a more in-depth assessment may be made.**

**PART I**

1. Is this screen being performed as part of the standard health screen (without specific problems being articulated?)

YES                      NO

If yes, skip to PART II.

If no, complete numbers 2 - 3 below before completing PART II.

2. Is this screen being performed because there is a mental health emergency? (Immediate danger to self/others due to suicidal/homicidal threats/gestures/attempts in response to mental illness or emotional disturbance)

YES                      NO

If yes, what is the emergency?

3. Is this screen being performed in response to someone in the child's environment who has expressed concern about her/his current mental health adjustment or because substance abuse is suspected?

YES                      NO

If yes, who expressed concern? \_\_\_\_\_

Relationship to the Child \_\_\_\_\_

What is the concern?

**PART II - DIRECTIONS**

Screeners should consider a child's age, developmental and intellectual level and overall functioning in identifying problems. Check the 2nd column if the problem has been observed within the last month. Check the 3rd column if the problem has ever been observed. Both columns can be checked or left blank.

CHILD'S PROBLEMS	In last month	Ever
1. Excessive irritability		
2. Overly sensitive to environment (noise, touch) which causes distress		
3. Excessive sadness, crying, withdrawal		
4. Excessive fears or worries, difficulty separating from parents, school refusal		
5. Recurrent intrusive thoughts or senseless repetitive behaviors, such as hand washing, lock checking, organizing objects		
6. Suicidal thoughts, threats, gestures or attempts		
7. Hallucinations (sees or hears things that aren't there), delusions (has strong beliefs which have no basis in reality)		
8. Difficulty in concentration		
9. Irregular or problematic sleep patterns		
10. Many nightmares		
11. Irregular or problematic eating/appetite patterns		
12. Problems in activity patterns (over-active or under-active )		
13. Injures self, e.g., cutting, head-banging		
14. Enuresis or Encopresis (wetting or soiling)		
15. Inability to give or receive appropriate affection to primary caregivers		
16. Inability to accept appropriate limits		
17. Easily angered or excessive anger or other strong emotion.		
18. Frequent, intense, uncontrollable temper tantrums		
19. Verbally threatening		
20. Physically violent		
21. Cruel to animals		
22. Willful destruction of property		
23. Fire setting		
24. Sexually preoccupied or inappropriate sexual activity		
25. Running away		
26. Suspected or confirmed abuse of alcohol or other drugs/substances		
27. Adolescent's pregnancy is/was related to behavioral/emotional difficulties		
28. Parenting (Youth is having trouble parenting his/her child(ren))		
29. Medical condition complicated by emotional disturbance or medical noncompliance		
30. Persistent unrealistic worry over physical health		
31. Problems in school/vocational activity (attendance, behavior, learning, performance)		
32. Suspected or confirmed victim of physical, sexual or emotional abuse		
33. Problems in interpersonal relationships (family and/or authority figures)		
34. Problems in interpersonal relationships (same age peers)		
35. Confirmed or suspected developmental delay		
36. Arrested, detained, or on probation		
37. Homicidal		
38. Gambling		
39. Avoids people, places or things		
40. Always seems jumpy or afraid		
41. Gets upset when remembering bad thing that have happened to him/her.		

PROBLEMS IN CHILD'S ENVIRONMENT	Within last month	Ever
1. Substance abuse and/or mental illness of biological parent(s)		
2. Substance abuse and/or mental illness of current caretaker(s) (if not living with biological parents)		
3. Substance abuse or mental illness of current household member (other than parent)		
4. Incarceration or arrest record of biological parent(s)		
5. Incarceration or arrest record of current caretaker (if not living with parents)		
6. Domestic violence		
7. Instability of residential arrangement, e.g., homelessness, multiple placements		
8. Psychosocial stressors, e.g., death, absence or loss of significant person in child's life and/or multiple life changes, serious illness in family, economic problems		
9. Inadequate or inappropriate parental supervision and/or discipline		
10. Suspected or confirmed victim of caregiver neglect, e.g. failure to provide food, shelter or clothing.		
11. Child has experienced traumatic event, e.g. flood, hurricane; frightening medical procedure; being or seeing someone severely injured (accident or assault); seeing a dead body or someone killed. Please explain _____ _____		

**Submission of this form does not constitute a formal abuse report. As a mandated reporter, a screener is legally obligated to report suspected child abuse or neglect to DFS. (1-800-292-9582)**

Any other problems not mentioned on this screen

**PART III Check one of the following:**

- A. \_\_\_\_\_ Child NOW has at least one of the problems listed in Part II but is currently receiving services to deal with them.
- B. \_\_\_\_\_ Child NOW has at least one of the problems listed in Part II and is not receiving services to deal with them.
- C. \_\_\_\_\_ Child does not NOW have any of the problems listed in Part II according to the screener.

**PART IV Check one of the following:**

- A. \_\_\_\_\_ Child has IN THE PAST had at least one of the problems listed in Part II and has received services to deal with them.
- B. \_\_\_\_\_ Child has IN THE PAST had at least one of the problems listed in Part II but has never received services to deal with them.
- C. \_\_\_\_\_ IN THE PAST, child has not had any of the problems listed in Part II according to the screener.

**NOTE:** The screener should make a referral to outpatient services if there is a check anywhere on this screen and the client has not received treatment to fully address the issue.

Screener Signature \_\_\_\_\_ Date \_\_\_\_\_

Agency/Position \_\_\_\_\_ Telephone \_\_\_\_\_

Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Revised 7/01/2006

Revised: 8/11/09

## **MENTAL HEALTH AIDE-REFERRAL FORM**

Please complete and attach to DPBHS referral packet when requesting aide services

Client Name \_\_\_\_\_ DOB \_\_\_\_\_

1. What goals need to be focused on?
  
2. How are these goals related to the current status in treatment/symptoms/diagnosis?
  
3. What interventions do you specifically want the aide to make to reach these goals?
  
4. Number of hours per week proposed?
  
5. What hours of the day/days of the week would be recommended?
  
6. What is the plan for parents to eventually and systematically learn how to take over the aide's responsibilities?
  
7. What is the estimated "length of stay" for the aide?
  
8. What would you consider to be reasonable discharge criteria for the aide?
  
9. How will the therapist and aide communicate with each other?