

MULTI-DISCIPLINARY CHILD PROTECTION TEAM REFERRAL

Client's Name _____
Last First M.I.

Age: _____ Date of Birth: ____/____/____ Gender M F Phone (____) _____

Address where the child is currently living: _____

How long has the child been at this address: _____

Siblings/Others in the household:

Name/Age: _____ Relationship: _____

Name/Age: _____ Relationship: _____

Name/Age: _____ Relationship: _____

Name/Age: _____ Relationship: _____

Address and phone if not living at home: _____

Guardian(s)/Caregiver(s)/Parent(s) name(s) and marital status:

Does the youth have a:

Guardian ad Litem Yes No Name/Phone Number: _____

Domestic Case Manager Yes No Name/Phone Number: _____

Educational Advocate Yes No Name/Phone Number: _____

Reason for Referral: (check all that apply)

- Criminal offenses(s) (e.g. assault, breaking and entering, theft, etc.)
- Status offense(s) (e.g. truancy, incorrigibility, runaway)
- Drug or alcohol abuse/dependence
- At risk of out-of-home placement
- Abused/neglected/abandoned by caregiver(s)
- Criminal victimization by adults other than care givers (i.e. victim of a crime perpetrated by someone outside of the family)
- School Suspensions, expulsions
- Aftercare following discharge from residential treatment/incarceration/hospitalization
- Threat of harm to self or to others
- Inability of caregiver(s) to provide stability or structure or control youth's behaviors
- Medical neglect
- Gaps in services
- Need for coordination of services
- Low resources / High need family
- Chronic agency involvement with insufficient process
- Other: _____

What kind of help are you looking for this youth and/or the family:

What agencies are involved with the youth and his or her family?

- | | |
|--|---|
| <input type="checkbox"/> Family Preservation / DCCCA | <input type="checkbox"/> Parents as Teachers |
| <input type="checkbox"/> The Guidance Center | <input type="checkbox"/> CASA |
| <input type="checkbox"/> Catholic Community Services | <input type="checkbox"/> SRS |
| <input type="checkbox"/> Private Mental Health Clinician | <input type="checkbox"/> The Farm, Inc. |
| <input type="checkbox"/> Special Education | <input type="checkbox"/> Fort Leavenworth Mental Health |
| <input type="checkbox"/> Riverside Resources | <input type="checkbox"/> Community Corrections |
| <input type="checkbox"/> Tiny-K Services | <input type="checkbox"/> Schools _____ |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |

Please circle those individuals who are involved with this youth in a significant way:

Relation	Name / Address / Phone Number
Mother	_____
Father	_____
Step-Mother	_____
Step-Father	_____
Older sibling(s)	_____
Maternal grandparents	_____
Paternal grandparents	_____
Foster parent(s)	_____
Boss	_____
Peer(s)	_____
Teacher	_____
Coach	_____
Aunt	_____
Uncle	_____
Neighbor	_____
Other / relationship to youth	_____
Other / relationship to youth	_____
Other / relationship to youth	_____

Have there ever been SRS reports filed on this youth?	Yes	No
When? _____	What was the nature of the reports(s)	Circle all that apply:
Physical abuse	Sexual Abuse	Emotional/Mental Abuse
		Neglect
		Truancy
Other _____		

Is the youth currently in SRS Custody? **Yes** **No**
 Name and phone number of case worker: _____

Is this youth currently involved with the court system? **Yes** **No**

Have the parents been notified of this referral? **Yes** **No**
 By Whom? _____

What other information do you feel is important for the MDCPT to know now?

Family Needs (Check all that apply)

- | | | |
|---|------------------------------------|--------------------------------------|
| <input type="checkbox"/> transportation | <input type="checkbox"/> clothing | <input type="checkbox"/> safety |
| <input type="checkbox"/> furniture | <input type="checkbox"/> food | <input type="checkbox"/> housing |
| <input type="checkbox"/> tutoring | <input type="checkbox"/> utilities | <input type="checkbox"/> child care |
| <input type="checkbox"/> access to healthcare | <input type="checkbox"/> hygiene | <input type="checkbox"/> other _____ |

1. **What specific services are being provided or have been provided to this youth and his/her family? (Please indicate if current or past services) (Example: Case Management)**

2. **How many times has this youth been admitted to a psychiatric hospital (lifetime)?** _____
For what reason? _____
When was the last time? _____
3. **How many times has this youth been arrested?** _____ **Incarcerated?** _____
Why? _____
4. **Is the youth in JJA custody?** _____ **On probation?** _____ **On diversion?** _____
Name and phone of worker / officer: _____
5. **How many times has this youth been placed out of the home in other settings (e.g., foster home, residential treatment facility, group home)?** _____
Where? _____
6. **With whom has the child lived over the past 5 years?** _____
Where? _____
7. **Are there existing court orders regarding this child? If so, in what state or jurisdiction?** _____
8. **How many times has this youth been suspended from school in the last year?** _____
How many total days? _____ Ever expelled? _____ What grade is the youth in? _____
What School does youth currently attend? _____ Enrolled in Special Ed. Classes? _____
Dropped out of school? _____ Achieved or working on a GED? _____
How many school has the youth attended in his or her lifetime? _____
9. **Has this youth made threats to kill other?** Yes No
10. **Has this youth ever attempted to kill or seriously harm others?** Yes No
11. **Has this youth made threats to kill or harm himself or herself?** Yes No
12. **Has this youth ever attempted to kill himself or herself?** Yes No
13. **What is this youth's psychiatric diagnosis?** _____

Who is completing this form?

_____ Name	_____ Phone
_____ Agency	_____ Date submitted

Who should the MDCPT representative contact after the initial screening is completed?

_____ Name / Agency	_____ Phone
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Email

Fax

Status of family needs:

_____ Urgent (why?) _____
_____ Chronic (just need ideas) _____

Please send this completed form to:

**Leavenworth County Multi-Disciplinary Child Protection Team
c/o CASA
100 S. 5th Street
Leavenworth, KS 66048
Fax: 913-651-6494**