NEW YORK STATE COUNCIL ON CHILDREN AND FAMILIES (CCF)
HARD TO PLACE/HARD TO SERVE INTAKE FORM

***Please fill out as completely as possible*.**

REFERRAL INFORMATION

Person making referral to CCF

_____ _____
First name Last name

Title of person making referral

Name of referring organization

Address of referring agency

_____
Street

_____ _____ _____
City State Zip

Phone number

(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ ___
Area code Number

Fax number

(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ ___
Area code Number

e-mail of person making referral to CCF

Date

_____ _____ _____
Month Day Year

CHILD/YOUTH INFORMATION

Child/Youth referred to CCF

_____ _____
First name Last name

Gender

Please specify child/youth's gender _____

Date of Birth

_____ _____ _____
Month Day Year

Race/Ethnicity

_____ African American _____ American Indian/Pacific Islander _____ Asian _____ Latino _____ Caucasian

_____ Two or more races/ethnicities

Legal Address of Child/Youth Being Referred:

_____
Street

_____ _____ _____
City State Zip

County

Diagnoses

_____

_____

_____

INTELLECTUAL FUNCTIONING		
(based on full scale IQ test)		
___ Very Superior (130+)	___Low Average (80-89)	___Severe Intellectual Disability (25-39)
___Superior (120-129)	___Borderline (70-79)	___Profound Intellectual Disability (below 25)
___High Average (110-119)	___Mild Intellectual Disability (55-69)	
___Average (90-109)	___Moderate Intellectual Disability (40-54)	

Expressive language skills	**Receptive language skills**
___ Uses appropriate speech skills	___ Understands complex statements/instructions
___ Uses simple speech skills (can indicate needs)	___ Understands simple statements/instructions
___ Uses manual language only (i.e., form of sign language)	___ Does not demonstrate understanding
___ Uses written symbol language only (i.e., Bliss, Rebus)	
___ Uses written language only	
___ No expressive language or has nonsensical speech	

Capacity for independent functioning	**Self-direction**
___ Has skills necessary for independent living	___ Manages personal affairs independently
___ Needs training to perform tasks for independent living	___ Needs assistance/training to manage personal affairs
___ Needs assistance to perform tasks for independent living	___ Is completely dependent on others for management
___ Is completely dependent on others	

Vision	Hearing	Mobility
___ No functional vision ___ Legally blind, has travel vision ___ Visually impaired ___ Vision normal *(includes vision corrected to normal)*	___ No functional hearing ___ Hearing impaired ___ Hearing normal *(includes hearing corrected to normal)*	___ No mobility ___ Wheelchair – needs assistance ___ Wheelchair – operated by self ___ Walks with supportive devices ___ Walks unaided with difficulty ___ Walks independently

Needs services of

_____ Foreign language interpreter _____ Sign language interpreter _____ Teacher of hearing impaired

_____ Teacher of orientation and mobility _____ Teacher of visually impaired

Behavior Frequency

__ No behavior disorder __ Weekly maladaptive behavior

__ Monthly maladaptive behavior __ Daily maladaptive behavior

__Describe behaviors of concern:

_____

Behaviors and risk factors *(check all that apply)*

__ Alcohol abuse	__ Emotionally fragile	__ Poor relationships with peers	__ Sleep problems
__ Academic problems	__ Explosive	__ Runaway from _____ Home _____ School _____ Program	__ Social contact avoidance
__ Acting out	__ Fire setting _____ Incidental _____ Chronic	__ Sad	__ Somatic complaints
__Antisocial	__ Hallucinations	__ Self-esteem poor	__ Steals objects/theft
__ Anxious	__ Has been involved in justice/juvenile justice system	__Sex abuse reactive	__Suicide attempts
__ Assaultive to family	__ Homicidal	__Sexually abused	__Suicidal ideation
__ Assaultive to peers	__ Impulsive/hyperactive	__ Sexually abusive	__ Substance abuse /dependence
__ Assaultive to adults	__Intimidates others	__ Sexually inappropriate	__ Trauma Triggers
__ Attention difficulties	__ Over dependent on others		__ Truancy
__ Cruelty to animals			__Vandalism

__ Danger to others __ Danger to self __Delusions __ Destroys property __ Easily victimized	__ Physical aggression __ Poor relationships with parents __ Poor relationships with other adults __ Poor relationships with authority	__Sexually provocative __Self-injurious __ Self-mutilation __Self-stimulation	__ Police contact __ Verbally abusive (extreme) __Wanders away from school or program

Judicial/Supervisory Status at time of referral (*check all that apply)*

_____ Criminal/civil charges pending _____ Family Court _____ PINS _____ Probation

Specify any pending charges:
_____

Special Care/ Medication Needs

___ Adapted physical education

___ Assistive technology (describe): _____

___ 24-hour prescription medications

___ Medical needs beyond administration of medications that require daily individualized attention from health care staff

___ 24 hour nursing care

___ Medical alerts (specify): _____
_____

SCHOOL DISTRICT INFORMATION	
Name of school district _____	
School contact person _____ First name _____ Last name	
Title of school contact _____	**Phone number of school contact** (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ ___ Area code Phone number
County of school district _____	**Email of school contact** _____

At the time of referral to CCF, what classification did the Committee on Special Education make for this child/youth?	**What is the class size of this child/youth at time of referral?**
_____ No classification has been made for child at this time _____ Autism only _____ Deaf blindness only _____ Hearing impairment only _____ Mental retardation only _____ Orthopedic impairment only _____ Other health impairment only _____ Serious emotional disturbance only _____ Speech or language impairment only _____ Specific learning disability only _____ Traumatic brain injury only _____ Visual impairment (includes blind) only _____ Multiple disabilities *(if multiple disabilities, specify types of disabilities)* _____ Autism _____ Deaf blindness _____ Hearing impairment _____ Mental retardation _____ Orthopedic impairment _____ Other health impairment _____ Serious emotional disturbance _____ Speech or language impairment _____ Specific learning disability _____ Traumatic brain injury _____ Visual impairment (includes blind)	_____ 12:1+1 _____ 8:1+1 _____ 6:1+1 _____ 6:1+3 _____ 2:1+4 _____ general education classroom

Related school services recommended for child/youth

__ Audiology __ Medical Services (evaluation) __ Psychological Services __ Speech Pathology

__ Assistive Technology Services __ Occupational Therapy __ Rehabilitation Counseling

__ Counseling Services __ Parent Education and Training __ School Health Services

__ Family Counseling __ Physical Therapy __ School Social Work

Other services needed:_____

PLACEMENT AT TIME OF REFERRAL TO CCF

Current living arrangement

_____ Living with parent(s) _____ Living with relative *(e.g., grandparent, sibling)* _____ Living independently

_____ Living in residential care _____ Homeless _____Living in Shelter/Respite

Current custody status

_____ Parent _____ Department of Social Services (LDSS) _____ Other custodian _____ Other family member ____ OCFS

(specify)_____

If divorced/separated, which parent has custody? _____Mother _____Father ____Joint Custody
If joint custody, which parent has physical custody? _____Mother _____ Father

Residential Placement *(Complete this section if child/youth is in a residential setting at time of referral to the Council)*			
Agency Affiliation			
_____ OPWDD	_____ OMH	_____ OCFS or _____ DSS *Select only one*	_____ SED
Type of OPWDD placement _____ Children's residence (CR) _____ Family care setting _____ Individual Residential Alternative (IRA) _____ Intermediate care facility (ICF) _____ Supported housing	*Type of OMH placement* _____ Community residence _____ Family based treatment _____ Psychiatric inpatient hospital _____ Residential treatment facility _____ Supported housing	*Type of OCFS/DSS placement* _____ Residential treatment center, group home, boarding home, foster care home _____OCFS Juvenile Rehabilitation Placement	*Type of SED/LEA placement* _____ Approved residential school

Name of residential program _____	**State where residential program is located** **(If out of state program only)** _____ _____ *(specify state abbreviation)*
Residential program contact person _____ *First name* _____ *Last name*	**Phone number of residential program contact** (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ ___ *Area code* *Phone number* Residential contact person email: _____

PARENT INFORMATION	
_____ Father name	_____ Mother name
Father phone(_____)_____	Mother phone(_____)_____
Father email _____	Mother email_____
Father address_____	Mother address_____
_____	_____
Guardian Information Name_____ Phone_____ Email_____ Address_____	**ADOPTION** Was this child/youth adopted? Yes_____ No_____ If yes, was the adoption domestic or International _____ If International which country _____

PLEASE PROVIDE THE FOLLOWING IN NARRATIVE FORM:

- *A DESCRIPTION OF THE BARRIERS ENCOUNTERED IN ATTEMPTING TO PROVIDE APPROPRIATE SERVICES OR PLACEMENT.*

- *A RECORD OF THE EFFORTS THAT HAVE BEEN MADE BY THE REFERRAL SOURCE OR OTHERS TO SECURE SERVICES AND/OR PLACMENTS FOR THE CHILD/YOUTH.*

- *BACKGROUND INFORMATION ON THE CHILD OR YOUTH'S SPECIAL NEEDS.*

- *PLEASE INCLUDE ANY ADDITIONAL COMMENTS OR INFORMATION THAT WOULD BE HELPFUL (use following page as needed).*