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.