



**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)

- | | | |
|---|---|--|
| <input type="checkbox"/> Very Superior (130+) | <input type="checkbox"/> Low Average (80-89) | <input type="checkbox"/> Severe Intellectual Disability (25-39) |
| <input type="checkbox"/> Superior (120-129) | <input type="checkbox"/> Borderline (70-79) | <input type="checkbox"/> Profound Intellectual Disability (below 25) |
| <input type="checkbox"/> High Average (110-119) | <input type="checkbox"/> Mild Intellectual Disability (55-69) | |
| <input type="checkbox"/> Average (90-109) | <input type="checkbox"/> Moderate Intellectual Disability (40-54) | |

Expressive language skills

- Uses appropriate speech skills
- Uses simple speech skills (can indicate needs)
- Uses manual language only (i.e., form of sign language)
- Uses written symbol language only (i.e., Bliss, Rebus)
- Uses written language only
- No expressive language or has nonsensical speech

Receptive language skills

- Understands complex statements/instructions
- Understands simple statements/instructions
- Does not demonstrate understanding

Capacity for independent functioning

- Has skills necessary for independent living
- Needs training to perform tasks for independent living
- Needs assistance to perform tasks for independent living
- Is completely dependent on others

Self-direction

- Manages personal affairs independently
- Needs assistance/training to manage personal affairs
- Is completely dependent on others for management



Vision <input type="checkbox"/> No functional vision <input type="checkbox"/> Legally blind, has travel vision <input type="checkbox"/> Visually impaired <input type="checkbox"/> Vision normal <i>(includes vision corrected to normal)</i>	Hearing <input type="checkbox"/> No functional hearing <input type="checkbox"/> Hearing impaired <input type="checkbox"/> Hearing normal <i>(includes hearing corrected to normal)</i>	Mobility <input type="checkbox"/> No mobility <input type="checkbox"/> Wheelchair – needs assistance <input type="checkbox"/> Wheelchair – operated by self <input type="checkbox"/> Walks with supportive devices <input type="checkbox"/> Walks unaided with difficulty <input type="checkbox"/> Walks independently
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Needs services of		
<input type="checkbox"/> Foreign language interpreter	<input type="checkbox"/> Sign language interpreter	<input type="checkbox"/> Teacher of hearing impaired
<input type="checkbox"/> Teacher of orientation and mobility	<input type="checkbox"/> Teacher of visually impaired	

Behavior Frequency	
<input type="checkbox"/> No behavior disorder	<input type="checkbox"/> Weekly maladaptive behavior
<input type="checkbox"/> Monthly maladaptive behavior	<input type="checkbox"/> Daily maladaptive behavior
<input type="checkbox"/> Describe behaviors of concern:	

Behaviors and risk factors <i>(check all that apply)</i>			
<input type="checkbox"/> Alcohol abuse <input type="checkbox"/> Academic problems <input type="checkbox"/> Acting out <input type="checkbox"/> Antisocial <input type="checkbox"/> Anxious <input type="checkbox"/> Assaultive to family <input type="checkbox"/> Assaultive to peers <input type="checkbox"/> Assaultive to adults <input type="checkbox"/> Attention difficulties <input type="checkbox"/> Cruelty to animals	<input type="checkbox"/> Emotionally fragile <input type="checkbox"/> Explosive <input type="checkbox"/> Fire setting <input type="checkbox"/> Incidental <input type="checkbox"/> Chronic <input type="checkbox"/> Hallucinations <input type="checkbox"/> Has been involved in justice/juvenile justice system <input type="checkbox"/> Homicidal <input type="checkbox"/> Impulsive/hyperactive <input type="checkbox"/> Intimidates others <input type="checkbox"/> Over dependent on others	<input type="checkbox"/> Poor relationships with peers <input type="checkbox"/> Runaway from <input type="checkbox"/> Home <input type="checkbox"/> School <input type="checkbox"/> Program <input type="checkbox"/> Sad <input type="checkbox"/> Self-esteem poor <input type="checkbox"/> Sex abuse reactive <input type="checkbox"/> Sexually abused <input type="checkbox"/> Sexually abusive <input type="checkbox"/> Sexually inappropriate	<input type="checkbox"/> Sleep problems <input type="checkbox"/> Social contact avoidance <input type="checkbox"/> Somatic complaints <input type="checkbox"/> Steals objects/theft <input type="checkbox"/> Suicide attempts <input type="checkbox"/> Suicidal ideation <input type="checkbox"/> Substance abuse /dependence <input type="checkbox"/> Trauma Triggers <input type="checkbox"/> Truancy <input type="checkbox"/> Vandalism



<input type="checkbox"/> Danger to others	<input type="checkbox"/> Physical aggression	<input type="checkbox"/> Sexually provocative	<input type="checkbox"/> Police contact
<input type="checkbox"/> Danger to self	<input type="checkbox"/> Poor relationships with parents	<input type="checkbox"/> Self-injurious	<input type="checkbox"/> Verbally abusive (extreme)
<input type="checkbox"/> Delusions	<input type="checkbox"/> Poor relationships with other adults	<input type="checkbox"/> Self-mutilation	<input type="checkbox"/> Wanders away from school or program
<input type="checkbox"/> Destroys property	<input type="checkbox"/> Poor relationships with authority	<input type="checkbox"/> Self-stimulation	
<input type="checkbox"/> Easily victimized			

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
_____	_____



<p>At the time of referral to CCF, what classification did the Committee on Special Education make for this child/youth?</p> <p> <input type="checkbox"/> No classification has been made for child at this time <input type="checkbox"/> Autism only <input type="checkbox"/> Deaf blindness only <input type="checkbox"/> Hearing impairment only <input type="checkbox"/> Mental retardation only <input type="checkbox"/> Orthopedic impairment only <input type="checkbox"/> Other health impairment only <input type="checkbox"/> Serious emotional disturbance only <input type="checkbox"/> Speech or language impairment only <input type="checkbox"/> Specific learning disability only <input type="checkbox"/> Traumatic brain injury only <input type="checkbox"/> Visual impairment (includes blind) only <input type="checkbox"/> Multiple disabilities (<i>if multiple disabilities, specify types of disabilities</i>) <ul style="list-style-type: none"> <input type="checkbox"/> Autism <input type="checkbox"/> Deaf blindness <input type="checkbox"/> Hearing impairment <input type="checkbox"/> Mental retardation <input type="checkbox"/> Orthopedic impairment <input type="checkbox"/> Other health impairment <input type="checkbox"/> Serious emotional disturbance <input type="checkbox"/> Speech or language impairment <input type="checkbox"/> Specific learning disability <input type="checkbox"/> Traumatic brain injury <input type="checkbox"/> Visual impairment (includes blind) </p>	<p>What is the class size of this child/youth at time of referral?</p> <p> <input type="checkbox"/> 12:1+1 <input type="checkbox"/> 8:1+1 <input type="checkbox"/> 6:1+1 <input type="checkbox"/> 6:1+3 <input type="checkbox"/> 2:1+4 <input type="checkbox"/> general education classroom </p>
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Related school services recommended for child/youth

<input type="checkbox"/> Audiology	<input type="checkbox"/> Medical Services (evaluation)	<input type="checkbox"/> Psychological Services	<input type="checkbox"/> Speech Pathology
<input type="checkbox"/> Assistive Technology Services	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Rehabilitation Counseling	
<input type="checkbox"/> Counseling Services	<input type="checkbox"/> Parent Education and Training	<input type="checkbox"/> School Health Services	
<input type="checkbox"/> Family Counseling	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> School Social Work	

Other services needed: _____

PLACEMENT AT TIME OF REFERRAL TO CCF		
Current living arrangement		
<input type="checkbox"/> Living with parent(s)	<input type="checkbox"/> Living with relative (<i>e.g., grandparent, sibling</i>)	<input type="checkbox"/> Living independently
<input type="checkbox"/> Living in residential care	<input type="checkbox"/> Homeless	<input type="checkbox"/> 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 <i>Select only one</i>	_____ SED
<i>Type of OPWDD placement</i>	<i>Type of OMH placement</i>	<i>Type of OCFS/DSS placement</i>	<i>Type of SED/LEA placement</i>
_____ Children's residence (CR) _____ Family care setting _____ Individual Residential Alternative (IRA) _____ Intermediate care facility (ICF) _____ Supported housing	_____ Community residence _____ Family based treatment _____ Psychiatric inpatient hospital _____ Residential treatment facility _____ Supported housing	_____ Residential treatment center, group home, boarding home, foster care home _____ OCFS Juvenile Rehabilitation Placement	_____ Approved residential school

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

PARENT INFORMATION

_____	_____
Father name	Mother name
Father phone(_____) _____	Mother phone(_____) _____
Father email _____	Mother email _____
Father address _____ _____	Mother address _____ _____

Guardian Information	ADOPTION
Name _____	Was this child/youth adopted? Yes _____ No _____
Phone _____	If yes, was the adoption domestic or International _____
Email _____	If International which country _____
Address _____	



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 PLACEMENTS 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).*

