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	**Fax number**
(_____) _____ - _____ Area code 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	**Date of Birth**
Please specify child/youth's gender _____	_____ _____ _____ 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 _____Intellectual Disability only _____Orthopedic Impairment only _____Other Health Impairment only _____Emotional Disability 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 _____Intellectual Disability _____Orthopedic Impairment _____Other Health Impairment _____Emotional Disability _____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	**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 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).*