Thank you for your interest in Catholic Charities Child and Adolescent Intensive Outpatient Day Treatment. We welcome inquiries about our program. A student will be placed on our Intensive Outpatient Day Treatment Referral List as an inquiry as soon as the Clinical Supervisor receives a phone call. Please call the Clinical Supervisor to schedule a tour of the Catholic Charities Child & Adolescent Intensive Outpatient Day Treatment program if desired. Intensive Outpatient Day Treatment services are available for students in grades 1–12, with enrollments of no less than six (6) months.

PLEASE NOTE: The referral process requires receiving the following information for student admission to our program. Referral Packet and forms are available on our website: www.ccstcloud.org/daytreatment

REQUIRED IMMEDIATELY:
- [ ] Health Insurance, Medical Assistance or Third-Party Information Form (Form 306)
- [ ] Copy of Health insurance, MA card or Third-Party insurance card, (copy front and back)

WHEN INSURANCE APPROVAL IS RECEIVED, THE FOLLOWING INFORMATION IS REQUIRED TO BE PROVIDED TO OUR OFFICE.
- [ ] Referral Packet (Form 101 and Form 112A)
- [ ] Consent of Release of Information & HIPPA Disclosure (Form 112)
  
  Please indicate name of agency and worker to contact for previous placement records. Parent signature is required to secure information from professionals who have worked with the child.

- [ ] Copy of current I.E.P.
- [ ] Copy of current Evaluation Report (ASR)

Copy of “Strengths & Difficulties Questionnaire” (SDQ) Form (2-sided) to be completed by Student
- [ ] S 11-17 for child age 11-17 years

Copy of “Strengths & Difficulties Questionnaire” (SDW) Form (2-sided) to be completed by Parent
- [ ] P 4-10 for child age 4-10 years
- [ ] P 11-17 for child age 11-17 years

Copy of “Strengths & Difficulties Questionnaire” (SDW) Form (2-sided) to be completed by Teacher
- [ ] T 4-10 for child age 4-10 years
- [ ] T 11-17 for child age 11-17 years

- [ ] Copy of Diagnostic Assessment/Psychological Evaluation with DSM IV.
  
  Completed within the last six (6) months

- [ ] Copy of Neuro-Psychological if one has been completed.

- [ ] Parent Completed Child/Adolescent Diagnostic Assessment Questionnaire – Part A

- [ ] Receipt of signed Service Agreement from School District

- [ ] Home school is responsible to set up transportation

  - When all of the above items have been received and when an opening occurs, the student will be considered for admission to the Intensive Outpatient Day Treatment Program.
  - Intake may or may not result after Diagnostic Assessment is completed and review of the above information by the Clinical/Program Supervisor.
  - Financial responsibility is with the designated School District.

Thank you for considering Catholic Charities Child and Adolescent Intensive Outpatient Day Treatment.
Catholic Charities Child & Adolescent Intensive Outpatient Program

Referral Packet

Date Completed __________________

(Office Only) Admit Date ______________

STUDENT INFORMATION

Full Name of Student __________________________ Nickname __________________________

Date of Birth ______________ Age _______ Grade: ______ Sex ☐ M ☐ F SS No. ______________________

Height _______ Weight _______ Eye Color _______ Hair Color _______ Birthplace ___________________

Religion __________________________ Race/Ethnicity __________________________ No. of years in USA __________

Language Spoken ___________________________ Language Written ___________________________

Confirmed transportation arrangements ☐ Y ☐ N

Person Making Referral __________________________ Phone (_______) ____________ Fax (_______) ____________

E-mail Address __________________________ County ________________ Case No ______________

Mailing Address __________________________ City/State/Zip ________________

Home School __________________________ School contacted ☐ Y ☐ N

Returning to Mainstream (Home) School ☐ Y ☐ N If no, where: ______________________________

Billable School District __________________________ Contact __________________________

Phone (_______) ____________ Fax (_______) ____________

Person(s) restricted from having contact with child

Name __________________________ Relationship __________________________

Name __________________________ Relationship __________________________

Catholic Charities Day Programs and ISD District 742 are legally required to inform both biological/adoptive parents of all special education meetings and decisions unless there is a court order restricting such contact. Please provide the following contact information so that staff may meet this legal requirement. NOTE: Step parents may not sign special education documents.

☐ There is a court order restricting contact. (Legal court documentation provided)

☐ Parental rights have been terminated. **(Legal court documentation provided)

☐ **Some one other than biological/adoptive mother or father is a legal guardian. (Legal court documentation provided.

Complete information below)
# PARENT/GUARDIAN INFORMATION

**Mother Name** _____________________________________________  Child Resides with this Individual  ☐ Y  ☐ N  
Marital Status  ☐ Married/Remarried  ☐ Divorced/Separated  ☐ Not Married  ☐ Widowed  
Custody (if applicable – requires copy of custody papers)  
Has Legal Custody of child  ☐ Yes  ☐ No  
Has Physical Custody of child  ☐ Yes  ☐ No  
E-mail Address ________________________________________________  
Mailing Address _____________________________________________  City/State/Zip ____________________________  
Phone Contact Numbers:  
1st choice (_______) ____________________  ☐ Home  ☐ Cell  ☐ Work  
2nd choice (_______) ____________________  ☐ Home  ☐ Cell  ☐ Work  
3rd choice (_______) ____________________  ☐ Home  ☐ Cell  ☐ Work  
Employer _____________________________________________________  Occupation ________________________________  

**Father Name** _____________________________________________  Child Resides with this Individual  ☐ Y  ☐ N  
Marital Status  ☐ Married/Remarried  ☐ Divorced/Separated  ☐ Not Married  ☐ Widowed  
Custody (if applicable – requires copy of custody papers)  
Has Legal Custody of child  ☐ Yes  ☐ No  
Has Physical Custody of child  ☐ Yes  ☐ No  
E-mail Address ________________________________________________  
Mailing Address _____________________________________________  City/State/Zip ____________________________  
Phone Contact Numbers:  
1st choice (_______) ____________________  ☐ Home  ☐ Cell  ☐ Work  
2nd choice (_______) ____________________  ☐ Home  ☐ Cell  ☐ Work  
3rd choice (_______) ____________________  ☐ Home  ☐ Cell  ☐ Work  
Employer _____________________________________________________  Occupation ________________________________  

**Progress or assessments reports/meeting invites should be sent to**  
☐ Mother  ☐ Father  ☐ County Case Mgr  
☐ Probation Officer  ☐ Guardian  ☐ Other ________________________________
If applicable, list Additional Guardian, Foster Parent, Surrogate, or Group Home information below:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relation to Student</th>
<th>E-mail Address</th>
<th>Student Resides at this location</th>
<th>Mailing Address</th>
<th>City/State/Zip</th>
<th>Phone (<em><strong><strong><strong>) Cell (</strong></strong></strong></em>) Work (_______)</th>
<th>Employer</th>
<th>Occupation</th>
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</table>
Student Name ________________________________

CONTACT INFORMATION

PMAP/County Case Manager __________________________ Phone (_______) ____________ Fax (_______) ____________
E-mail Address ___________________________________ PMAP worker/County worker contacted □ Y □ N
Mailing Address __________________________________ City/State/Zip ________________________________

Probation Officer __________________________________ Phone (_______) ____________ Fax (_______) ____________
E-mail Address ___________________________________ County ______________ Case No _____________
Mailing Address __________________________________ City/State/Zip ________________________________

Guardian Ad Litem __________________________________ Phone (_______) ____________ Fax (_______) ____________
E-mail Address ___________________________________ City/State/Zip ________________________________
Mailing Address __________________________________

Surrogate ________ __________________________________ Phone (_______) ____________ Fax (_______) ____________
E-mail Address ___________________________________ City/State/Zip ________________________________
Mailing Address __________________________________

Home School Contact Person __________________________ E-mail Address _________________________________
Mailing Address __________________________________ City/State/Zip ________________________________

EMERGENCY CONTACT INFORMATION

Emergency Contact #1 ______________________________ Relation to Student _________________________________
Mailing Address __________________________________ City/State/Zip _________________________________
Phone (_______) ____________ Cell (_______) ____________ Cell (_______) ____________

Emergency Contact #2 ______________________________ Relation to Student _________________________________
Mailing Address __________________________________ City/State/Zip _________________________________
Phone (_______) ____________ Cell (_______) ____________ Cell (_______) ____________

Emergency Contact #3 ______________________________ Relation to Student _________________________________
Mailing Address __________________________________ City/State/Zip _________________________________
Phone (_______) ____________ Cell (_______) ____________ Cell (_______) ____________

Dentist ______________________________ Phone (_______) ____________
Name/Office ______________________________________ Mailing Address _________________________________
City/State/Zip ________________________________

Physician/Medical Office ______________________________ Phone (_______) ____________
Name/Office ______________________________________ Mailing Address _________________________________
City/State/Zip ________________________________
**Student Name ______________________________________**

**EDUCATION INFORMATION**

School last attended _____________________________________________ School District # __________ Grade _________

IEP Manager/School Contact Person ___________________________ Graduation Year ______________

Phone (_______) ____________      Fax (_______) ____________

Resident District Name (if different than above) ______________________________________ Resident District # _____________

IEP Manager/School Contact Person ______________________________________________

Phone (_______) ____________      Fax (_______) ____________

Was child on an IEP  Y  N  504 Plan  Y  N  Copy of IEP & Special Ed Evaluation Report Attached  Y  N

Services Received ____________________________________________________________________________________________

Disability Areas ______________________________________________________________________________________________

Academic Adaptations/Modifications _____________________________________________________________________________

Testing Adaptations/Modifications _______________________________________________________________________________

Passed MN Grad Tests – Person Completing Form _______________________________________

Math  Y  N  Date Passed ________   Reading  Y  N  Date Passed ________   Writing  Y  N  Date Passed _______

IEP/ER/504 sent to program facilitator  Y  N

**PRESENTING PROBLEMS/SYMPTOMS**

Check the 1st box for all that apply and check 2nd box for those you want addressed in treatment

| 1. Nonverbal/unable to communicate | 23. Self-mutilating, head banging, scratching, hair pulling |
| 2. Compulsive/repeats certain acts over and over | 24. Self-esteem problems |
| 3. Cruel to animals | 25. Sexually assaultive, molesting others |
| 4. Depressed, sad or unhappy | 26. Sexual problems, behaviors, sexual identity |
| 5. Disobedient, oppositional | 27. Relationship difficulty with siblings(s) |
| 6. Fights or physically attacks people | 28. Sleep problems |
| 7. Fire setting | 29. Stealing |
| 8. No remorse | 30. Stubborn, sullen, irritable |
| 9. Hyperactive, restless | 31. Suicidal ideation or attempts |
| 10. Impulsive (acts without thinking) | 32. Vandalism, destroys property |
| 11. Suffering with loss or grief | 33. Verbally abusive, threatening |
| 12. Lying or cheating | 34. Wets bed or wets during day, enuretic |
| 13. Soils pants, encopretic | 35. Younger acting than own age |
| 14. Relationship difficulty with parent/parent figure | 36. Gang involvement |
| 15. Relationship difficulty with peers/others own age | 37. Documented emotional abuse |
| 16. Phobias, unreasonable fears | 38. Documented physical abuse |
| 17. Prostitution or pimping | 39. Documented physical neglect |
| 18. Racial/ethnic identity confusion/issues | 40. Documented sexual abuse |
| 19. Reality perceptions distorted | 41. Truancy |
| 20. Runs away | 42. Lacks academic motivation |
| 21. Verbal tantrums | 43. Developmentally disabled (M.R.) |
| 22. Learning disabled |

**Legal History** (Check all that apply)

- Court-ordered placement: Date ______________   *Please attach or send court order.
- Termination of Parents Rights Date_______________
- Adopted:  Yes  No   Age Adopted: _________________________
- E.J.J.  CHIPS
- Nonstatus Offender  Voluntary Placement
- Status Offender  State Ward
- Felony Offender

*If any restraining orders are current, please attach or send.*
MEDICATIONS

This student can not be admitted to our program without an appropriate supply of medication and written doctors’ orders for dispensing this medication. Please contact the Catholic Charities Program Coordinator at (320) 650-1561 if you have specific questions.

List child’s current medications and current dosage

<table>
<thead>
<tr>
<th align="left">Medication:</th>
<th align="left">Dosage</th>
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Psychiatrist Name ___________________________________________ Phone (______) ________ - ____________
Clinic _______________________________________________ Fax (______) ________ - ____________
Clinic Address _________________________________________ City/State/Zip _______________________________

Current/Most Recent Diagnosis

Axis I

__________________________________________________________________________________________________

Axis II

__________________________________________________________________________________________________

Axis III

__________________________________________________________________________________________________

Physical Condition/Health *(Please check all that apply)*

☐ Neurological Impairment (explain) ________________________________
☐ Auditory Impairment (explain) ________________________________
☐ Mobility Impairment (explain) ________________________________
☐ Speech Impairment (explain) ________________________________
☐ Visual Impairment (explain) ________________________________
☐ Allergies (explain) ________________________________
☐ Pregnancy (stage) ________________________________
☐ Special Medical Care (explain) ________________________________
☐ Asthma
☐ Diabetes
☐ Other (explain) ________________________________
Student Name ______________________________________

REFERRAL INFORMATION

Reason for Referral __________________________________________________________

____________________________________________________________________________

Interventions Prior to Referral __________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Student’s Strengths ____________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Child’s Stressors at School ______________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Has student been referred to another alternative program? □ Yes □ No

If yes, which program __________________________________________________________

List other services student receives ______________________________________________

____________________________________________________________________________

____________________________________________________________________________

What is the current Post-Treatment/Assessment Placement Plan?

□ Parent(s) home

□ Foster home

□ Group home

□ Transfer to open/less-structured program

□ Other (Specify) ______________________________________________________________

These referral forms were completed by

□ Mother □ Father □ Guardian □ PMAP/County Case Mgr □ Probation Officer

□ Hospital Social Worker □ Other __________________________________________________

Name __________________________________________________________________________
Student Name ______________________________________

Catholic Charities Child & Adolescent Intensive Outpatient Day Treatment

Referral Form

1712 7th Avenue South, St Cloud MN 56301

Riverwoods School Information/Records

School Phone: 320-650-1500    School Fax: 320-229-6010

☒ Please confirm Transportation Arrangements

☒ Please e-mail the Riverwoods MARSS Secretary

Deborah.danell@isd742.org when you have the inactivated the student at your school (320-650-1542)

☒ Please give this page to your Guidance Department and have them FAX the following school records at least two (2) days PRIOR to the intake date.

ATTN: Karla Klein @ fax: 320-229-6010 or phone: 320-650-1586

☐ Current transcript (including grades to date of withdrawal)

☐ MARSS # (Minnesota State ID#)

☐ Health and Immunization Records

☐ MN State Testing Results

☐ Psychological/Diagnostic/Achievement Testing

☐ Attendance/Discipline/Suspension Records

☐ School Social History

Any questions regarding the Riverwoods School program, please contact Randy Arnold at 320-650-1500.
Catholic Charities Child & Adolescent Intensive Outpatient Day Treatment

Consent for Release of Information & HIPPA Disclosure

1712 7th Avenue South, St Cloud MN 56301

Note: All items on this form MUST be completed to insure prompt release of information. If the form is incomplete, it will be returned and no information will be released until it is properly completed. The date of signature must not pre-date treatment.

<table>
<thead>
<tr>
<th>Patient/Client</th>
<th>Name:</th>
<th>Date of Birth:</th>
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<td>Address:</td>
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<td>City</td>
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<td>Zip</td>
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<tr>
<td>Previous Name:</td>
<td>Social Security Number:</td>
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<th>I Authorize Release of Information from:</th>
<th>Name:</th>
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<th>I Authorize Release of Information to:</th>
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<tr>
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<td>Intensive Outpatient Day Treatment Programs – Catholic Charities of the Diocese of St Cloud</td>
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<td>Address:</td>
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<td>1712 7th Avenue South</td>
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<td>City</td>
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<tr>
<th>I Authorize records to be obtained and/or released for services covering these dates:</th>
<th>Dates of Service</th>
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<td>(Information completed/checked to be released)</td>
<td>From:</td>
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<td>To:</td>
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<td>Admission/Intake Summary/Diagnostic Assessment</td>
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<td>Progress Reports, Treatment Records, ER Reports</td>
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<td>Social History</td>
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<td>Social Service Records</td>
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<td>Discharge or Closing Summary</td>
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<td>Psychiatric Evaluation</td>
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<td>Medical History/Physical Exam/Laboratory Reports</td>
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<td>Psychological Testing or Evaluation</td>
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<td>Chemical Dependency Evaluation</td>
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<td>Other: __________________________________________________________________</td>
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| Requested records may be used to: (Please check all that apply) | To coordinate services |
|                                                                 | To participate in consultation |
|                                                                 | To acknowledge referral |
|                                                                 | To transfer treatment |
|                                                                 | For legal purposes |
|                                                                 | To access insurance information |
|                                                                 | Other: __________________________________________________________________|
| Requested Information may also be released |   
|------------------------------------------|---|
|   - Verbally – conversation with contact person   |   |
|   - In writing – copies of original records may be sent |   |
|   - Both |   |

**Revocation**

This authorization will remain in effect a maximum of one year (12 months) from the date of signature and may be cancelled by me in writing at any time. I understand that such cancellation may be harmful to proceedings requiring these records. I do not authorize re-release of this information to anyone. A photocopy of this authorization will be treated in the same manner as the original.

**Authorization:**

I authorize the above provide to release the information marked above to the requester. A photocopy shall be as valid as the original.

<table>
<thead>
<tr>
<th>Patient/Guardian Signature</th>
<th>Date</th>
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<tbody>
<tr>
<td>Relationship to Patient</td>
<td>Reason Patient is unable to sign</td>
</tr>
<tr>
<td>Witness or Agency Representative</td>
<td>Date</td>
</tr>
</tbody>
</table>
Catholic Charities Child & Adolescent Intensive Outpatient Program

Authorization for Release of Information

In our efforts to provide Intensive Outpatient Services, we provide joint programming with the St. Cloud Children’s Home, Riverwoods School and Day Programs. As a result, the purpose of the disclosure is to assist program staff with assessment, treatment and after care.

Day Programs Staff:
☒ Restrictive interventions will be reviewed by licensed professionals from Day Programs per MN Sessions Law #245.8261.

Riverwoods Staff:
☒ School records
☒ Weekly updates to and from clinical and academic staff
☒ Meeting notes from quarterly, initial and intake staffings
☒ Treatment plan and restrictive intervention plans/incident reports
☒ Calming plans
☒ Contact information students and families name and address
☒ Diagnostic Information
☒ Reintegration and discharge planning to be shared with new school and/or same school that the student attended.
☒ Academic testing information
☒ Discipline reports and incident information
☒ Medical records forwarded from home school to assist in planning, implementing and reporting education
☒ Riverwoods School Psychologist only to review psychological reports – no copies on site

St Cloud Children’s Home Staff: (in order for us to give care while in the SCCH building)
☒ Allergy information
☒ Behavior intervention information

St Cloud Children’s Home Nursing Staff: (in order to distribute medications)
☒ Medical record information
☒ Medication distribution forms
☒ Doctor’s consent for medical distribution
☒ Emergency medical information

Please initial appropriate statements below:
☐ OK to fax my medical information to me or to others when necessary
☐ OK to send appointment reminders
☐ OK to leave detailed messages (ie: lab or test results, anything to do with your care):
  ☐ voicemail  ☐ home voicemail  ☐ family member

Signature of Parent/Guardian ____________________________ Date ____________  Signature of Office Personnel ____________________________ Date ____________