***Within 21 calendar days of qualifying significant incident (as indicated on this form below), please complete fully and submit with a current (within 30 days) CANS and current, valid CSA consent to exchange information***

|  |
| --- |
| **DEMOGRAPHICS INFORMATION** |
| **Youth Information** |
| Youth Name: enter text. | DOB: enter a date. | Sex: Select |
| CANVAS# *(if known)*:enter text. | Private Insurance: Select | Medicaid: Select |
| Race: Click to select item. | Hispanic Origin: Select  |
| Address: Click or tap here to enter text. | City: enter text | State: enter text. | ZIP: enter text. |
| **PARENT/GUARDIAN INFORMATION** |
| Parent Guardian 1: |
| Name: Click or tap here to enter text. |
| [ ]  *Check here if address is same as above* | Address: Click or tap here to enter text. |
| City: enter text. | State: enter text. | ZIP: enter text. | Locality: enter text. |
| Phone: enter text. | Email: enter text. |
| Parent Guardian 2: |
| Name: enter text. |
| [ ]  *Check here if address is same as above*  | Address: enter text. |
| City: enter text. | State: enter text. | ZIP: enter text. | Locality: enter text. |
| Phone: enter text. | Email: enter text. |
| **CASE MANAGER INFORMATION** |
| Name: enter text. | Agency: enter text. |
| Phone: enter text. | Email: enter text. |
| **PARENTAL CONTRIBUTION INFORMATION** |
| [ ]  Youth is currently open to and receiving CSA-funded services (refer to copayment assessment on file)[ ]  Youth is a new referral to CSA; copayment waiver is requested |
| **AGENCY CONTACTS** ***(please indicate contact name and if status is past, current or NA)*** |
| [ ]  CSB (Behavioral Health/DDS*)* | Name: Click or tap here to enter text. | Status: Select |
| [ ]  School | Name: Click or tap here to enter text. | Status: Select |
| [ ]  DFS  | Name: Click or tap here to enter text. | Status: Select |
| [ ]  Juvenile Court | Name: Click or tap here to enter text. | Status: Select |
| [ ]  Public Heath | Name: Click or tap here to enter text. | Status: Select |
| [ ]  NCS | Name: Click or tap here to enter text. | Status: Select |
| [ ]  OFC | Name: Click or tap here to enter text. | Status: Select |
| [ ]  Community Provider | Name: Click or tap here to enter text. | Status: Select |
| [ ]  DBHDS Crisis Stabilization  | Name: Click or tap here to enter text. | Status: Select |

|  |
| --- |
| **CURRENT / IMMEDIATE NEEDS** |
| DSM Diagnosis: Click or tap here to enter text. | Medications: Click or tap here to enter text. |
| Youth and Family Strengths: Click or tap here to enter text. |
| Brief description of current needs: Click or tap here to enter text. |
| **SIGNIFICANT INCIDENT(S)** *(check all that apply):* |
| [ ]  | Acute Psychiatric Hospitalization | enter a date. |
| [ ]  | CSB Emergency Services Evaluation | enter a date. |
| [ ]  | Emergency Department Boarding | enter a date. |
| **REQUESTED IN-HOME SERVICES** *(please select one for 60-day timeframe)* |
| [ ]  ISS **OR**  [ ]  FSS-IFPS | Dates: start date **-** end date. |

**Signatures**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Case Manager’s Name |  | Case Manager Signature |  | Date |
|  |  |  |  |  |
| Supervisor’s Name |  | Supervisor’s Signature |  | Date |