INTERAGENCY TEAM MEETING NOTIFICATION

Date: _____

To: Child and Adolescent Unit

From: Agency Contact Person_____

Phone Number of Contact Person _____

Agency Name_____

CBH Provider # _____

CHILD INFORMATION

Child name: _____ MA#: _____ Date of birth_____

Special Needs: ☐ Mental Retardation ☐ PDD Spectrum Disorder ☐ Other _____

Systems Involved: ☐ Education: Current Grade_____ ☐ Special Education: (check) ☐ LS ☐ ES

☐ Other_____

☐ DHS Involvement: (check) ☐ Foster Care ☐ SCOH ☐ Juvenile Justice

☐ Targeted Case Management: (check) ☐ Intensive CM ☐ Resource CM ☐ Mental Retardation CM

☐ Community Resources (specify): _____

Referral Status: ☐ Initial ☐ Continuing Services

If continuing services, is child receiving all requested services? ☐ Yes ☐ No

If no, which services are not being provided? ☐ TSS ☐ BSC ☐ MTY ☐ RTF ☐ Other_____

Indicate why not provided: ☐ Staffing issues ☐ Child improved ☐ Other _____

MEETING INFORMATION

Meeting date_____Meeting time _____

Location: ☐ Family home ☐ Agency ☐ School (specify): ☐ Other:_____

Location Address: Street_____

City_____State _____Zip Code _____

Persons Invited: ☐ Parent(s)/Guardian(s) ☐ Child/Adolescent ☐ Family/Parent Advocate ☐ MH Staff

☐ School Personnel ☐ DHS Worker ☐ Foster Care Worker/Parent(s) ☐ SCOH Worker

☐ Child Advocate ☐ Juvenile Probation Officer ☐ Primary Care Physician

☐ Other_____

Meeting Type: ☐ General ☐ Wraparound ☐ Partial Hospital ☐ RTF ☐ Other_____

Comments: _____

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