COMAL ISD
KEYSTONE
PROGRAM

SS/HS Case-Management Process

1. SS/HS Case Manager receives a referral regarding CISD student via the pony, fax, phone contact, mail, or in person. SS/HS Referral Form is utilized and completed.
2. Case Manager initiates the Referral through follow-up contact with referral source *and / or* other professional on the school campus *and* with the student indicated, to obtain additional information regarding the referral and the students' situation.
3. Student is assessed to determine needs, and availability of services to address those needs within the Keystone Program or via other School / Community providers.
   **IF during this process, the referral is deemed more appropriate for Special Education Services, the referral will be forwarded to the appropriate Special Education Coordinator.*
4. Case Manager makes initial contact with Parent/Guardian during the Assessment Process and to receive consent for services through the Keystone Program. Consent for SS/HS services is received.
   **When contact with parent/guardian can not be made after several attempts, a letter is sent to students' home address with information about the program and how to contact a Case Manager.*
5. Student is opened for SS/HS-Keystone services and/or referred to other community resources for services.
6. Case Manager makes referral to appropriate SS/HS partnering agency and notifies school of when services are to begin.
7. Case Manager completes the Quick View Form.
8. Case Manager sends follow-up letter to referral source, regarding the students' status within the SS/HS Program and services that will be received by the student and family.
9. Case Manager initiates monthly follow-up contact with student and/or family or contracted service provider to monitor progress.
10. Case Staffings are held with partnering agencies to discuss student's status / progress and need to continue with services. Staffings will be held at a minimum of 8 week intervals.
11. Monthly Case Management reports including; Pending Referrals, and Students receiving Direct and Indirect services are submitted on a monthly basis to Campus Administrators, Counselors, SS/HS Prevention Education Specialists and Lizzie by the 5th of each month.

COMAL ISD
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REFERRAL FORM

Student Name _____ Student ID _____

Campus _____ Grade _____ DOB _____

Please indicate areas of concern for the student you are referring. Rate your concern 5-1 (with 5 being the greatest concern.)

Areas of Concern:

Academics (working below apparent ability, dramatic drop in performance)

5 4 3 2 1 N/A

Health (inconsistent attendance, suspicion of substance abuse, general health concerns)

5 4 3 2 1 N/A

Social (poor interaction with peers, faculty/staff)

5 4 3 2 1 N/A

Emotional (increased sensitivity or anger, mood swings)

5 4 3 2 1 N/A

Attitude/Motivation (aggressive or distant behavior, apathy)

5 4 3 2 1 N/A

Objective comments about above:

_____

_____

Have you spoken with the student in question about your concern? Yes No

Have you contacted or consulted with the parent regarding your concerns? Yes No

Any other agencies involved with the student/family?

_____

The Case-Manager works to coordinate services for students and their families that are meaningful, community-based mental health services and other relevant community-based services. Students are referred to these services for non-academic related issues, based on a thorough assessment of their needs.

_____ _____/_____/_____

Name of Person Referring Date

_____ _____/_____/_____

Keystone Case Manager Signature Date

Client's Name	Date of Intake:

CONSENT TO PROVIDE SERVICES AND RELEASE OF INFORMATION

Comal Independent School District (CISD) Safe Schools / Healthy Students Keystone Program

Contact Information

Street Address:		City, State, Zip:	
County of Residence:	Home Phone:	Emergency Contact Name and Phone:	
Client's Social Security Number:	Client's Date of Birth:	Client's District School:	Grade:

Consents

By checking and initialing the services listed below, I give my consent for the ***Comal Independent School District*** (CISD) via it's ***Safe Schools/Healthy Students*** program to provide the following services:

☐ Assessments _____ ☐ Parenting Classes _____ ☐ Case Management _____
☐ Individual Counseling _____ ☐ Group Counseling _____ ☐ Family Counseling _____

By checking and initialing the services listed below, I give my consent for the ***Comal County Juvenile Probation Department*** to provide the following services as part of the ***Safe Schools/Healthy Students*** program:

☐ Assessments _____ ☐ Family Counseling _____ ☐ Case Management _____
☐ Individual Counseling _____ ☐ Group Counseling _____ ☐ ***Other*** __________ _____

By checking and initialing the services listed below, I give my consent for the ***Hill Country Mental Health Mental Retardation Agency (MHMRA)*** to provide the following services as part of the ***Safe Schools/Healthy Students*** program:

☐ Assessments _____ ☐ Crisis Counseling _____ ☐ Case Management _____
☐ Individual Counseling _____ ☐ Group Counseling _____ ☐ Family Counseling _____
☐ Aftercare Services _____ ☐ Psychiatric Services _____ ☐ ***Other:***__________ _____

By checking and initialing the services listed below, I give my consent for ***Communities In Schools of South Central Texas*** to provide the following services as part of the ***Safe Schools/Healthy Students*** program:

☐ Assessments _____ ☐ Family Support _____ ☐ Case Management _____
☐ Individual Services _____ ☐ Group Services _____ ☐ ***Other:***__________ _____

By checking and initialing the services listed below, I give my consent for ***Connections*** to provide the following services as part of the ***Safe Schools/Healthy Students*** program:

☐ Assessments _____ ☐ Group Counseling _____ ☐ Case Management _____
☐ Individual Counseling _____ ☐ Family Counseling _____ ☐ ***Other:***__________ _____

By checking and initialing the services listed below, I give my consent for ***McKenna Memorial Hospital*** to provide the following services as part of the ***Safe Schools/Healthy Students*** program:

☐ Assessments _____ ☐ Early Childhood Services _____ ☐ Family Counseling _____
☐ Individual Counseling _____ ☐ Group Counseling _____ ☐ ***Other:***__________ _____

By checking and initialing the services listed below, I give my consent for the ***Comal/Guadalupe/Kendall County Adult Education Cooperative*** (CGKC-AEC) to provide the following services as part of the ***Safe Schools/Healthy Students*** program:

☐ English 2nd Language _____ ☐ G.E.D. Services _____ ☐ ***Other:***__________ _____

By checking and initialing the services listed below, I give my consent for ______________________________ to provide the following services as part of the ***Safe Schools/Healthy Students*** program:

☐ ***Other:*** __________ _____ ☐ ***Other:*** __________ _____ ☐ ***Other:***__________ _____

By checking and initialing the services listed below, I give my consent for ______________________________ to provide the following services as part of the ***Safe Schools/Healthy Students*** program:

☐ ***Other:*** __________ _____ ☐ ***Other:*** __________ _____ ☐ ***Other:***__________ _____

By checking and initialing the services listed below, I give my consent for ______________________________ to provide the following services as part of the ***Safe Schools/Healthy Students*** program:

☐ ***Other:*** __________ _____ ☐ ***Other:*** __________ _____ ☐ ***Other:***__________ _____

By checking and initialing the services listed below, I give my consent for ______________________________ to provide the following services as part of the ***Safe Schools/Healthy Students*** program:

☐ ***Other:*** __________ _____ ☐ ***Other:*** __________ _____ ☐ ***Other:***__________ _____

Client Comments/Notes

Release of Information

By checking and initialing the agencies listed below I give my permission for those agencies to give and receive information about _____.
Client's Name

	Initials	*Date*
☐ *Comal Independent School District*	____	____
☐ *Comal County Juvenile Probation Department (CCJPD)*	____	____
☐ *Hill Country Mental Health Mental Retardation Agency (MHMRA)*	____	____
☐ *Communities In Schools of South Central Texas*	____	____
☐ *Connections*	____	____
☐ *McKenna Memorial Hospital (specifically excludes patient healthcare information)*	____	____
☐ *Comal/Guadalupe/Kendall County Adult Education Cooperative (CGKC-AEC)*	____	____
☐ *Other:* _____	____	____
☐ *Other:* _____	____	____
☐ *Other:* _____	____	____
☐ *Other:* _____	____	____
☐ *Other:* _____	____	____

The information shared by the agencies checked and **initialed** above will be limited to the following items listed below:

☐ Client's Name ____	☐ Client's Phone Number ____	☐ Client's Address ____
☐ School Behavior Records ____	☐ School Attendance Records ____	☐ Program Attendance ____
☐ Progress Notes ____	☐ Case Staffing Notes ____	☐ School Grades ____

☐ **Other:** _____ ____
☐ **Other:** _____ ____
☐ **Other:** _____ ____
☐ **Other:** _____ ____

Client Comments/Notes

Confidentiality

Confidentiality is a part of nondisclosure/privacy concerning all issues discussed in a counseling session. Confidentiality is mandated by law, which staff members must follow. The law includes the following exceptions in which a staff member must report the following information to the appropriate authority:

(1) The verbal or written threat of suicide or homicide,
(2) The emotional, physical or sexual abuse or neglect of a child, the elderly or handicapped person, and/or
(3) A court order requesting counselor files.

In addition, the staff member may disclose confidential information under the following circumstances:

(1) For case consultations or supervision,
(2) For evaluation and research purposes conducted on behalf of the funding source(s),
(2) For auditing purposes through the agency or funding source(s), and/or
(3) When a signed and written ***Release of Information*** is completed (e.g. this form).

Signature(s)

I have read and understand the above information, and it has been explained to me by a program staff member. I consent for _____ to receive services provided by the agencies identified above and
Client's Name
for those agencies to share the information noted above and understand this consent and release of information will remain in effect until **September 1, 2011**, the last day of grant funding, or until this consent and/or release of information is revoked, which ever occurs first.

_____	_____	_____	_____
Adult/Parent/Guardian	*Date*	*Client*	*Date*
_____	_____	_____	_____
Staff	*Date*	*Witness (If Needed)*	*Date*