Wakulla County School District

Mental Health Handbook

Revised July, 2022

Wakulla County School District
Mental Health Handbook

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Evidence Based Mental Health Services

Tier I:

Pre-K Kagan, Good Behavior Game

K-5 PBIS, Kagan, Changing and Growing (4th grade), AVID (CES/MES), ELA/Social Studies (Florida Standards district wide curriculum), Guidance Curriculum, Promoting Student Happiness (SES}, Zones of Regulation (CES), Sanford-Harmony Social Emotional Learning (SEL) Curriculum (K-5th)

6-8 PBIS, Kagan, AVID, Healthy Choices (grades 6-8), Five Star Life SEL Curriculum

9-12 PBIS, Kagan, AVID, Healthy Choices (grade 9), SEL Curriculum

Tier II:

Small group or individual instruction/support on topics such as managing grief (loss); conflict resolution; making healthy decisions; developing positive communication skills; anger management; self-advocacy; organizational skills; strategies for coping with anxiety; coping with depression and time management. Instruction or support will be done by school counselors, school social workers, deans of student services, and mental health professionals from agencies contracted or partnering with Wakulla County School District.

Tier Ill: Individual counseling based on the individual's diagnosis or referral. This counseling is typically provided on a weekly basis by a mental health professional. Types of therapies will vary by the needs of the student but can include any of the following evidence based treatments:

- **Cognitive-Behavioral Therapy [CBT] (e.g., relationship between thoughts, feelings, and behaviors; identifying triggers and developing adaptive coping skills, challenging cognitive distortions such as "black and white" or "all or nothing" thinking styles)**
- **Dialectical Behavior Therapy (DBT) (e.g., empirically based framework to increase Distress Tolerance skills, Interpersonal skills, Emotion Regulation skills, and Mindfulness)**
- **Direct Instruction for Social Skills**
- **Social Perspective Taking (e.g., thinking about what others are thinking)**
- **Self-Regulation Behavioral Strategies (e.g., deep breathing, progressive muscle relaxation, visualization)**
- **Assertive Communication Strategies**
- **Problem-Solving Strategies**
- **Solution-Focused Problem Solving (e.g., identifying barriers to desirable outcomes such as coming to school and strategies to overcome those barriers)**
- **School and parent behavioral consultation (e.g., establishing self-monitoring forms with teacher prompting, use of check-and-connect for truancy)**

Supports that Address Mental Health Needs (assessment, intervention and treatment)

Mental Health Trainings:

All District Staff-Youth Mental Health First Aid, Mandatory Reporting

Instructional Staff and School Administrators- Trauma Informed Care; Suicide Prevention; Restorative Discipline

Guidance Counselors/Associate Deans of Student Services: Youth Mental Health Train the Trainer

Coordination of Service Providers:

- **At the beginning of each school year there will be a joint meeting held with school guidance department, mental health teams and mental health service providers to insure a seamless referral process and communication for Tier II and III intervention and treatment.**
- **A member of the district mental health team will attend monthly meetings of the Wakulla County Coalition for Youth and provide resources and information to each school counselor and dean of student services for dissemination to teachers, students and families.**

Assessment:

- **Tier I assessment will be based on the Early Warning System (EWS) in FOCUS. The EWS tracks attendance below 90%, suspensions, course failure in ELA or Math and Level 1 scores on State Assessments.**
- **Tier II and III assessment will be based initially on referrals from families, teachers, data provided from mental health professionals, student self-referrals, the EWS and exit data from case management notes, and achievement of service plan goals.**

Intervention and Treatment:

- **Tier I supports and interventions will be provided by classroom teachers and include: Social Emotional Learning (SEL) Curriculum K-12; AVID (both middle and high schools); PBIS K-12; Use of Kagan strategies K-12; Anti Bullying lessons at middle and high school; anti bullying (The Real Me Project) at elementary; SAVE (Substance Abuse Violence Education) at 5th grade district wide; Good Behavior Game at pre-K; Healthy Choices (elementary district wide); guidance lessons elementary district wide and 9th grade seminar for all high school freshmen (includes lessons on organization, self-advocacy, decision making and career decisions).**
- **Tier II intervention and support will be provided by certified or licensed personnel (deans of student services; school counselors, mental health professionals, social workers and partnering agency counselors). They will be delivered in small groups or individual sessions and topics will cover grief/loss; anger management; conflict resolution; communication skills; diversity; anxiety; and other topics based on teacher/student/family referrals.**
- **Tier III assessment, interventions and treatment will be provided in the form of individual therapy/counseling by district school social workers or partnering service providers, using a variety of research/evidence based methods and based on student needs. *Students who bring or threaten to bring weapons on campus will be evaluated by an LCSW. Following a Baker Act all reentry meetings will be facilitated by a school social worker.**

Evidence Based Mental Health Services for Students with One or More Co-Occurring Mental Health or Substance Abuse Diagnosis and Students at Risk of Such Diagnosis

- **Students with One or More Co-occurring mental health or substance abuse diagnoses will be identified based on parent/student disclosure on school registration and/or school medical information.**
- **Students will be monitored through the EWS to ensure that Tier I supports are effective. If the student is need of more intense services/accommodations, the school RtI team will meet and problem solve, and refer for evaluation under Section 504 or IDEA. The district Mental Health Coordinator will also be a part of the RtI team and will ensure that referral for Tier II or III mental health interventions are implemented.**
- **Students who have been evaluated and referred to the psychiatric center two or more times will be referred to the district CAT (Community Action Team) and information will be shared with the School Safety Team for additional problem solving.**

Collaborative Partnerships with Community Providers and Agencies

Contracted Services:

- **Florida State University Multidisciplinary Center-psychology interns provide Tier 2/3 mental health counseling**
- **Behavior Management Consultants-provide behavioral interventions by Board Certified Behavioral Analysts and develop FBAs (Functional Behavioral Assessments) and BIPs (Behavior Intervention Plans)**
- **Dr. Gaelyn Wolf-Bordonaro-provide art therapy services to elementary students with emotional/behavioral disorders**
- **Resounding Healing-provide music therapy services for students with disabilities who have sensory needs.**

Memorandums of Understanding:

- **Disc Village-provide counselors for substance abuse and decision making in secondary schools**
- **Capital City Youth Services- work with at-risk and homeless youth and provide counseling within the schools**
- **Community Wellness Counseling & Support Services – provides counseling and support services for at-risk youth within the schools and home**
- **Wakulla County Health Department- provides Tier I lessons on decision making; assisting parents/families with understanding cyber bulling and recognizing risky technology applications.**
- **Northwest Florida Health Network and Department of Children and Families-provides the opportunity to share information regarding students in the Dependency System and problem solve to provide interventions to meet their needs.**
- **Apalachee Center, Inc.-provides a Mobile Response Team located at the Apalachee Center, Inc. (Crawfordville) that will respond to a student in crisis immediately via phone and in person, if needed, within 60 minutes of receiving the call. 24 Hour Hotline Number: 1 800 342-0774**

Record Keeping:

School Based Counseling (Google Forms)

- **Grades K-5-When a student requests to speak to a counselor, the school Guidance Counselor/Associate Dean of Student Services will enter the school, student's name, date, time and the reason for the request into a school specific Google form on the designated student services computer. School administrators will also have access to Google forms.**
- **Grades 6-12-Students requesting to speak with a counselor will enter their school, name, date, time, and reason for the request into a school specific Google form on the designated Student Services computer. School administrators will also have access to Google forms.**

Referral for Services with Partnering Agencies (FOCUS)

- **Administrators, teachers, student services personnel or parents may request that a student is referred for counseling/services.**
- **The school Guidance Counselor/Associate Dean of Student Services will complete the referral and submit to the District Mental Health Coordinator (Not to individual service providers).**
- **A school social worker will talk to the student within 5 days, to see if services are needed and contact the parent/legal guardian to determine if a referral for services is requested.**
- **The District Mental Health Coordinator and Licensed Clinical Social Workers will determine the appropriate service provider and refer the student for services within 15 days.**
- **Parents will be given the List of Service Providers via email or hard copy as needed.**
- **The District Mental Health Coordinator will enter information into a confidential tab in FOCUS: Student name, grade, school center, referral requested by, referral submitted by, referred to which service provider, type of counseling requested (group, individual, CAT Team}**
- **When a student is assessed for a Baker Act, the District Mental Health Coordinator or LCSW will enter information into a confidential tab in FOCUS.**
- **The District Mental Health Coordinator will enter information into the confidential tab regarding student participation/nonparticipation in provided counseling services.**
- **The Mental Health Coordinator will conduct weekly or bi-weekly checks with service providers to ensure students are participating in services.**
- **If students are not participating in services provided, a phone call/meeting will be held with school personnel, school social worker, and parents/guardians to determine barriers and problem solve.**

Parent Notification of Services

This document contains the procedures for notifying a student's parent if there is a change in the student's services or monitoring related to the student's mental, emotional, or physical health or well-being and the school's ability to provide a safe and supportive learning environment for the student. Wakulla County School Board will not adopt procedures or student support forms that prohibit school district personal from notifying a parent about a student's mental, emotional, or physical health or well-being, or a change in related services or monitoring, or that encourage or have the effect of encouraging a student to withhold from a parent such information. Wakulla County School Board will follow all guidelines set forth by House Bill 1557.

Wakulla County Schools
Student Services Department
Baker Act Procedures and School Re-entry

Baker Act Procedures

A student qualifies for a Baker Act evaluation if the student expresses or exhibits the intent to inflict bodily harm to self or others, including death by suicide or homicide. Intervention and de-escalation techniques shall begin when any staff member identifies or is made aware of a student's possible intent to commit bodily harm to self or others. The purpose of the Baker Act is to provide those in crisis with immediate access to mental health assessment and intervention services The Baker Act (Sections 394.451-394.47892, Fla. Stat. 2018). Wakulla County School Board will follow all guidelines set forth by House Bill 945. This requirement does not supersede authority of a law enforcement officer to act under s. 394.463.

1. **The staff member identifying that the student is in crisis should contact a school administrator or school counselor immediately. The student should never be unsupervised at any time. Supervision must be maintained by a designated staff member until evaluation can occur by the Licensed Clinical Social Worker or School Resource Officer.**

2. **The administrator or his/her designee must immediately contact the Licensed Clinical Social Worker who will assess the student to determine if a Baker Act is appropriate. The School Resource Officer will share pertinent information and collaborate with the Licensed Clinical Social Worker. If an LCSW is not available, the School Resource Officer will perform the assessment.**

3. **The LCSW or designee should notify the Director of Student Services, District Mental Health Coordinator, Chief Academic Officer, Coordinator of Safety and Risk Management and Superintendent of all Baker Act evaluations, regardless of the outcome of these evaluations.**

4. **If the Baker Act is warranted, the following will occur:**

    a. **SRO or law enforcement designee will follow Wakulla County Sheriff's Department protocol for transportation to the Central Receiving Facility.**
    b. **The LCSW or SRO will contact the parent/guardian as soon as possible regarding the mental health concerns.**
    c. **The LCSW or designee will complete the Suicide/Baker Act Intervention Checklist.**

5. **If the Baker Act is NOT warranted, the following will occur:**
    a. **LCSW or designee will contact parent/guardian as soon as possible and request that the parent/guardian come to school to discuss concerns involving the safety of their child and/or others.**
    b. **LCSW or designee will complete Parent Acknowledgement Form prior to student leaving school. The LCSW or designee will make recommendations to the parent/guardian for further evaluations as well as providing contact information about the nearest available providers for appropriate follow up.**

c. The LCSW or designee will complete the Suicide/Baker Act Intervention Checklist

6. If there are concerns that child abuse or neglect may exist, the school administrator or designee will follow procedures for mandatory child abuse and neglect reporting to the Department of Children and Families.
7. Student Services/Guidance, LCSW, SRO and Mental Health Team will meet annually during pre-planning to review this process and make changes as needed.

School Re-entry after any Baker Act or other Psychiatric Evaluation

The LCSW or designee will facilitate the following re-entry procedures when a student has been discharged from a psychiatric evaluation by a physician.

1. Facilitate a re-entry meeting with a team including the student, parent/guardian, school counselor or administrator, and any other parties invited or requested by student or parent/guardian.
2. During this re-entry meeting, attempt to obtain Parent Permission for Release of Information form to communicate with the hospital or physician treating the student.
3. Interview the student and parent to determine what agencies may be providing services to the student.
4. Inform the parent/guardian of additional resources that may be available to the student and/or family.
5. Obtain the needs of the student and develop the Student Safety Plan.
6. Notify teachers of the student's return date and encourage them to allow the student appropriate time to make up assignments.
7. Collaborate with the school counselor or Associate Dean of Student Services to provide follow up services to meet the students' needs, such as weekly check-in, monitoring of mental health status, missed class work, etc.

Out of School Baker Act Notification Procedures:

1. Wakulla County Sheriff's Office notifies School Safety Specialist and District Mental Health Coordinator of Baker Act.
2. District Mental Health Coordinator calls principal/designee of school the student attends (secondary contact if first cannot be reached) and LCSW.
3. District Mental Health Coordinator follows-up with a text/ email to principal/designee and LCSW.
4. The LCSW will facilitate a re-entry meeting with a team including the student, parent/ guardian, school counselor or administrator, and any other parties invited or requested by student or parent/guardian.

Wakulla County Schools
Suicide/Baker Act Intervention Checklist

Student Name_____ DOB_____
School _____ Grade_____
Has this student had a previous Baker Act evaluation? **Yes** **No** **Unknown**
Dates of previous evaluations/hospitalizations: _____
Does the Student have current Mental Health Providers? **Yes** **No**
If yes, have they been notified of this evaluation? **Yes** **No**

Suicide risk interview conducted Date/Time_____

Conducted by: _____ Title_____

Meets Baker Act criteria **Yes** **No**
If yes, WCSO contacted: Name_____ Date/Time_____
Notes:

Parent contacted Date/Time_____

Contacted by: _____ Title_____

Name of parent contacted: _____
Phone Number: _____
Is parent available for Face-to-Face conference? **Yes** **No**
If no, why? _____
Notes:

Parent Conference Participants:
Name_____ Title/Position_____
Name_____ Title/Position_____
Name_____ Title/Position_____
Name_____ Title/Position_____
Name_____ Title/Position_____

Conducted by:_____Title/Position: _____
Personnel notified:
Name_Bobby Pearce_____ Title/Position_ Superintendent_____
Name_Sunny Chancy _____ Title/Position_Director of Instruction_____
Name_Belinda McElroy_____ Title/Position_Director of ESE_____
Name_Amy Bryan_____ Title/Position_Mental Health Coordinator__
Name_Jim Griner_____ Title/Position_Safety and Risk Manager___
Name_Lt. Jeremy Johnston____ Title/Position_Wakulla Co. Sheriff's Office_
Name_____ Title/Position_WCSO/SRO_____
Name_____ Title/Position_School Administrator(s)____
Name_____ Title/Position_Student Services Staff_____
Name_____ Title/Position_School Social Worker _____

Complete this section only if abuse/neglect is suspected.
Abuse Hotline Called Date/Time_____

Conducted by: _____ Title_____
Hotline Staff: _____ ID#_____
Notes:

Adapted COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen with Triage Points for Schools

	Past month	
Ask questions that are in bold and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you had any actual thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***Have you been thinking about how you might do this?*** e.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		
4) ***Have you had these thoughts and had some intention of acting on them?*** as opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	**Lifetime**	
If YES, ask: ***Was this within the past 3 months?***	**Past 3 Months**	

Student School Mental Health Safety Plan

Wakulla County School District

Date of Meeting: _____Dates Hospitalized: _____
Student Name and Birthday: _____
Participants and Relationship: _____
_____

1. What is the main reason you were hospitalized? _____
   _____

2. TRIGGERS: When these things happen, I am more likely to feel unsafe and upset:

☐ Not being listened to ☐ Feeling pressured ☐ Being touched ☐ Lack of privacy ☐ People yelling ☐ Loud noises ☐ Feeling lonely ☐ Arguments ☐ Not having control ☐ Being isolated ☐ Darkness ☐ Being stared at ☐ Being teased ☐ Particular time of day/person/season/reminder:

_____

3. WARNING SIGNS: These are things other people may notice me doing if I begin to lose control:

☐ Sweating ☐ Breathing hard ☐ Clenching fists or gritting teeth ☐ Red faced ☐ Wringing hands ☐ Loud voice ☐ Acting hyper ☐ Swearing ☐ Bouncing legs ☐ Rocking ☐ Pacing ☐ Crying ☐ Squatting ☐Damaging things ☐ Avoiding people ☐ Laughing loudly ☐ Becoming very quiet

4. INTERVENTIONS: These are things that might help me calm down and keep myself safe when I'm feeling upset:

☐ Time out ☐ Listening to music ☐ Reading a book ☐Sitting with staff ☐ Talking with friends ☐ Talking with an adult ☐ Coloring ☐ Humor ☐ Exercising ☐ Writing in a journal ☐ Ripping a blank sheet of paper ☐Getting a hug ☐Using the gym ☐Bouncing a ball ☐Deep breathing ☐Drawing ☐Crying ☐Being around others

5. ESCALATIONS: These are things that do NOT help me calm down or stay safe and/or make me feel worse:

☐Being alone ☐Being around people ☐Humor ☐Not being listened to ☐Loud tone of voice ☐Being ignored ☐Talking to an adult ☐Being reminded of the rules ☐Being touched

6. What is something you are looking forward to:
   _____

Calling for help: **800-273-8255** (Suicide Prevention Lifeline) Texting for help: text "help" to **741741**
Adults at school I can go to for help: _____
_____
Current Services/Medications: _____
_____

Safety Plan Meeting Attendees Signatures

Student: _____

Parent: _____

Social Worker: _____

Student Services Staff: _____

School Administrator: _____

School Resource Officer: _____

Health Coordinator: _____

Community Provider Signatures:

_____ _____

_____ _____

_____ _____

_____ _____

Teacher Signatures:

Please sign and date when you have reviewed this document and agree to uphold the agreed upon safety plan:

_____ _____

_____ _____

_____ _____

_____ _____

Release of Information Signed by parent ☐ yes ☐ no

Records Requested from hospital ☐ yes ☐ no

Wakulla County Schools

PARENTAL PERMISSION FOR RELEASE OF INFORMATION
OR REQUEST FOR REVIEW OF STUDENT INFORMATION

Date:_____

I, _____

(Parent/Guardian/18 year old Student)

Hereby authorize Wakulla County Schools and

- o Apalachee Mental Health, 43 Oak St, Crawfordville, FL 32327
- o Apalachee, PATH & Eastside Psychiatric Hospital, 2634-B Capital Circle NE, Tallahassee, Florida 32308
- o Capital City Youth Services (CCYS, 2407 Roberts Ave, Tallahassee, FL 32310
- o DISC Village, 85 High Drive, Crawfordville, Florida 32327
- o Department of Children and Families, 69 High Drive, Crawfordville, Florida 32327
- o Tallahassee Memorial Behavioral Health Center, 1616 Physicians Drive, Tallahassee, FL 32308
- o Wakulla County Health Department, 48 Oak St, Crawfordville, FL 32327
- o Other _____

To exchange information regarding my child/children

Student's Legal Name	Birth Date	School
Student's Legal Name	Birth Date	School
Student's Legal Name	Birth Date	School

Which includes:

☐	Psychological data	☐	Dates of attendance/treatment
☐	Section 504 Records	☐	Treatment Plan
☐	Adaptive behavior scales	☐	Intake Summary
☐	Social/Medical History	☐	Discharge Summary
☐	Present levels of subject area performance	☐	Grades
☐	ESE records including IEP	☐	Other:

This Information is to be released for the following purpose(s):

___Counseling ___Coordination of mental health services ___Other _____

To: _____
(Name)

_____
(Address)

_____
(Fax #)

THESE RECORDS MAY NOT BE RELEASED TO **ANOTHER PARTY AND/OR AGENCY WITHOUT PRIOR APPROVAL** OF THE **PARENT/GUARDIAN AND/OR ELIGIBLE STUDENT.**

NOTE: In providing my consent to the release of records, I understand that the Information will be released in the form of copies of written records. I have a right to inspect any records released pursuant to this Consent. I understand that I may revoke this Consent by providing written notice to the Principal of the school from which records are being requested. I further understand that until this revocation is made, this Consent shall remain In effect for the current school year and educational records will continue to be provided to the agency specified for the specific purpose(s) listed above. New Parent Consent to Release Student Information forms must be completed for each subsequent school year.

Authorized Signature Date

Relationship

Address

Home Telephone

City State Zip

If no number, please give a number where you can be contacted

WMIS S52176; Rev. 12/14

Wakulla County Schools
Student Services Department

Procedures for Completing the Parent Acknowledgement Form for Students At-Risk of Suicide or At-Risk of Causing Serious Harm to Others

Procedures:

Any time a student of the Wakulla County School District expresses suicidal or self-harm thoughts or intent, or poses a credible threat of causing serious bodily harm to others, their parents/guardians must be notified. The Baker Act Procedure portion of this handbook provides guidance regarding assessment. In the event the Licensed Clinical Social Worker (LCSW) or School Resource Officer determines that a student does not meet the Baker Act Criteria, the parent/guardian should be informed of their child's statements/actions that led to the evaluation through discussion and completion of the Parent Acknowledgment Form for Student At-Risk of Suicide or Causing Serious Harm to Others. Attach the list of nearby children's behavioral health providers, and their contact information. This form should be completed and signed at the face-to-face parent meeting before the child leaves school for the day.

In the event that parents/guardians are not residing together and both parents cannot be present for face-to-face conference before the child leaves school, the parent not present will be mailed a copy of the Parent Acknowledgment Form for Students At-Risk of Suicide or Causing Serious Harm to Others to the address on file In the District Information Management System file by the end of the school day.

The Parent Acknowledgment Form for Student At-Risk of Suicide or Causing Serious Harm to Others will be completed by a trained LCSW, school counselor, Associate Dean of Student Services, Assistant Principal, or Principal. This documentation will be maintained in the LCSW's office at the Wakulla County School District Office, and should not be included in a student's cumulative records, health records, or ESE files. During transition between schools, the LCSW or designee should verbally discuss a student's history of Baker Act evaluations and safety plans with the school counselor or Associate Dean of Student Services at the student's new school.

Parent Acknowledgement Form for Student At-Risk of Suicide or At-Risk Causing Serious Harm to Others

School: _____

Date: _____

Student: _____

As the parent/guardian of _____, I have the authority and responsibility to make decisions on behalf of my child and to sign this document. I acknowledge that I have been advised by school staff member _____ on this date that my child has expressed suicidal ideations and may be at risk for suicide or poses a credible threat of causing serious bodily harm to others.

I understand that I have been advised that my child does not currently meet criteria for an involuntary commitment under the Baker Act (Sections 394.451-394.47892, Fla. Stat. 2018) but this could change at any time. I understand that there are professionals available to help maintain my child's safety if their suicide risk or their risk of causing serious bodily harm to others increases. Furthermore, I agree to call for help from law enforcement or take my child voluntarily to the nearest children's behavioral health center if his/her situation worsens. Attached is a list of nearby children's behavioral health centers and their contact information.

I understand that Wakulla County School District Policy requires me to notify the school counselor or dean of student services if my child is hospitalized so that we can meet and prepare for a successful return to school.

I understand that I have been advised to take my child to the appropriate medical and/or mental health providers for further evaluation and treatment. Attached is a list of available agencies and providers that may be able to help, but it is not a requirement to use this list. The school counselor or dean of student services can assist me with the referral process. The school district is not responsible for evaluation expenses for outside service providers.

I understand that the Licensed Clinical Social Worker, School Counselor, or Associate Dean of Student Services will follow up with me and my child within ten business days from the date of this letter, as well as at other times that the principal, assistant principal school counselor, dean of student services, or licensed clinical social worker determines is appropriate.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____ Phone Number: _____

Staff Signature: _____ Date: _____

Witness (If parent/guardian unable to sign): _____

Reason parent/guardian is unable to sign: _____

Wakulla County Schools
Student Services Department

Procedures for Completing the Refusal of Mental Health Services Forms

Procedures:

In the event that a parent is refusing mental health services for their child, in general or after a Baker Act, a face-to- face meeting must be called. Participants should include the parents, the LCSW, guidance Counselor/Associate Dean of Student Services, a school administrator, and the district mental health coordinator. The reasons and data for the referral for services should be explained to the parent. Every effort should be made to ensure that services will begin or continue. If the parent continues to refuse the mental health services provided by the Wakulla County School District, the parent will be asked to sign the "Refusal of Mental Health Services" form.

The Refusal of Services Form will be completed by a trained LCSW, school counselor, Associate Dean of Student Services, Assistant Principal, or Principal. This documentation will be maintained in the LCSW office at the Wakulla County School District Office and should not be included in a student's cumulative records, health records, or ESE files.

In the event that parents are not residing together and both parents cannot be present for face-to-face conference, the parent not present will be mailed a copy of the Refusal of Mental Health Services Form to the address on file in the District Information Management System by the end of the school day.

Refusal of Mental Health Services Form

School Center_____ Date of Parent Meeting_____

Name of Student_____ Date of Birth _____

Current Grade_____
Meeting Participants:

Team Member Role	Signature
Parent/Guardian	
Administrator/Designee	
Guidance Counselor/Associate Dean of Student Services	
Licensed Clinical Social Worker	
Teacher	
Other:	
Other:	

I _____have been informed by the Wakulla County School District of concerns regarding my child's mental health. Based on evidence discussed at this meeting, the Wakulla County School District would like to coordinate mental health services by a mental health professional at no charge. I am refusing those services for my child.

Reason for Refusal:

___ I do not feel that my child requires mental health services/treatment.

___ I will arrange services/treatment for my child by a certified/licensed mental health professional on my own.

Other: _____

_____

_____ _____
Signature of Parent/Guardian Date

_____ _____
Administrator/Designee Signature Date

Parent Refusal of Mental Health Services for Student At-Risk of Suicide

School:
Date:
Student:

As the parent/guardian of _____, I have the authority and responsibility to make decisions on behalf of my child and to sign this document. I acknowledge that I have been advised by school staff member _____ on this date of the Wakulla School Board approved Re-entry Procedures located in the Mental Health Handbook and listed below.

School Re-entry after any Baker Act or other Psychiatric Evaluation

The LCSW or designee will facilitate the following re-entry procedures when a student has been discharged from a psychiatric evaluation by a physician.

1. Facilitate a re-entry meeting with a team including the student, parent/guardian, school counselor or administrator, and any other parties invited or requested by student or parent/guardian.

2. During this re-entry meeting, attempt to obtain Parent Permission for Release of Information form to communicate with the hospital or physician treating the student.

3. Interview the student and parent to determine what agencies may be providing services to the student.

4. Inform the parent/guardian of additional resources that may be available to the student and/or family.

5. Obtain the needs of the student and develop the Student Safety Plan.

6. Notify teachers of the student's return date and encourage them to allow the student appropriate time to make up assignments.

7. Collaborate with the school counselor or Associate Dean of Student Services to provide follow up services to meet the students' needs, such as weekly check-in, monitoring of mental health status, missed class work, etc.

I have read and understand that the Wakulla County School Board Policy above requires me to notify the school counselor, social worker or an administrator if my child is hospitalized so that we can meet and prepare for a successful return to school.

I understand and am refusing mental health services at school for my child who has been recently hospitalized and/or expressed suicidal ideations and may be at risk for suicide.

I understand and am refusing to create a Safety Plan and to notify the teachers of possible triggers, warning signs, interventions, and escalations regarding my child's mental health.

I understand that there are professionals outside of school available to help maintain my child's safety if their suicide risk increases. Furthermore, I understand that it is my responsibility and agree to call for help from law enforcement or take my child voluntarily to the nearest children's behavioral health center if his/her situation worsens.

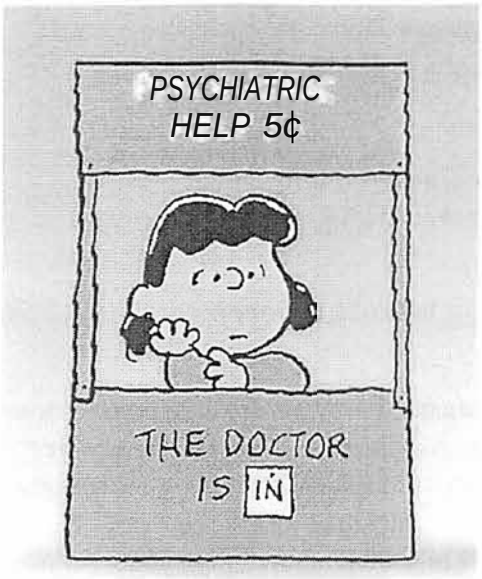
Parent Signature:_____ Date: _____

Printed Name: _____ Phone Number: _____

Staff Signature :_____ Date: _____

Witness (If parent unable to sign): _____

Reason parent is unable to sign: _____



List of

Service Providers

Children's Behavioral Health Centers: (both are open 24 hours per day, 7 days per week)

1. **Apalachee Center Central Receiving Facility 2634 Capital Circle NW, Tallahassee, FL 32308 850-523-3333**

2. **Tallahassee Memorial Hospital Behavioral Health Center 1616 Physician's Drive, Tallahassee, FL 32308 850-431-5100**

No-Cost Wakulla County Mental Health Services

- Apalachee Center
  - Apalachee Children's Outpatient Program provides psychiatric evaluations, medication management, therapy and case management services. Services are provided in the home, at the office, or at school. School based services include individual counseling and case management.
  - 43 Oak Street, Crawfordville, FL 32327
  - Contact Anne Vinson at 926-5900 for more information
  - **Mobile Crisis Response Team Hotline Number 1-800-342-0774**

- Big Bend Hospice
  - The Caring Tree is designed to meet the needs of children and teens who are grieving. This program creates a safe and therapeutic environment in which young people and the adults around them can learn to understand and cope with loss. Both short and long term services are available.
  - Services offered include group or individual grief counseling either in the school or at the Crawfordville office.
  - Any student who has experienced loss is eligible for services.
  - Contact 850-878-5310 for more information
  - Local support counselor is Caitlyn Burns, LCSW 850-671-6074

- Capital City Youth Services (CCYS)
  - The Family Place offers non-residential counseling services to families who may or may not be in crisis
    {with school age youth) in the Big Bend region of North Florida. Services are generally available within 24-48 hours. We offer family, individual, and group counseling; early intervention for families in crisis, consultation and referrals to other agencies; comprehensive assessment, treatment planning and case management. Services provided are free and confidential.
  - Contact Rebecca Salter- Referral Coordinator - Youth and Family Counselor-850-597-3039
  - Contact Jane Hernandez-Youth and Family Counselor-850-509-5802
  - Contact Sharon Bonpracer-Youth and Family Counselor-850-728-4637
  - Crawfordville location at 7 Holly Avenue, Crawfordville, FL 32327

- In Tallahassee, there is also a respite program for youth (Someplace Else), a residential program (Transitional Living), and a street outreach program (Going Places). Call 850-576-6000 for questions about these services

- DISC Village-New Horizons
  - New Horizons is an evidence-based substance abuse prevention program for students. The program offers a safe and supportive environment for students to discover and strengthen their abilities to make positive life choices. In this program students will learn positive decision-making, coping skills, communication skills, healthy self-esteem, anger management, healthy and unhealthy relationships, and the dangers of alcohol, tobacco and other drugs.
  - New Horizons programs available at WHS, WMS and RMS

Wakulla County Area Mental Health Services

- A Time To Change
  - Offers both family and individual counseling services at their Crawfordville location.
  - A variety of insurances are accepted
  - 2140-B Crawfordville Highway, Crawfordville, FL 32327 o
    Phone: 850-926-1900

- Avalon Treatment Centers o
    18 and over only
  - Addiction Counseling, Domestic Violence, DWSLR classes, Anger Management
  - Joanna Johnson, MSW, CAC, CCFC
  - An LCSW and an additional Certified Addiction Counselor also available
  - Office can be reached at 850-727-8728; address is 3047 Crawfordville Highway, Crawfordville, FL 32327

- Camelot Community Care, Inc.
  - Camelot Community Care's Counseling Program provides community based individual and family counseling and psychiatric services to clients in their home, school or their office. Camelot addresses various aspects of child and adolescent mental health including emotion, behavior and conduct disruptions. This program serves children ages 4-18 who have qualifying Florida Medicaid.
  - 1000 West Tharpe Street, Suite 7, Tallahassee, FL 32303
  - For more information, call 850-561-8060

- DISC Village
  - Adult and adolescent outpatient substance abuse therapy
  - 85 High Drive, Crawfordville, FL 32327
  - 850-926-2452

- Discovery Place
  - Discovery Place provides comprehensive counseling services providing traditional psychotherapy and substance abuse treatment. Meditation, relaxation techniques, art, writing and music therapy are all used to promote personal growth and gain awareness in self and others.
  - 322 Beard Street (mid-town) Tallahassee, Florida 32303
  - Accepts a variety of insurances and all ages are eligible
  - Contact Rita Haney at 850-502-2912 for more information

- Florida Therapy Services, Inc.
  - Florida Therapy provides psychiatric consultation, medication management, individual and family therapy utilizing cognitive behavioral, insight-oriented and supportive therapy, and group therapy to develop interpersonal skills and problem-solving strategies. ·

- Main office located at 1834-A Jaclif Court, Tallahassee, FL 32308
- Medicaid eligible starting at age 4, commercial insurance (except CHP) as well as self-pay options
- Contact 877-234-5351 for more information

- Play Big Therapy
  - Targeted sensorimotor therapy in combination with social emotional therapy;
  - Intense, frequent therapeutic play designed to stimulate dendritic growth of the neurons and strengthen neurological pathways.
  - Brain growth allows children to process their world more automatically and efficiently, freeing higher brain centers to be available for learning.
  - Physical, occupational, speech, play, art therapies and targeted case management
  - 4500 W Shannon Lakes Drive, Tallahassee, Fl 32309
  - 850-942-2000

- Healing Transitions
  - PATRICIA ANN CRAVEN, PHO, LMFT-S, RPT-S
  - 1310 Cross Creek Circle, Suite A, Tallahassee FL 32301; Phone Number: (850) 877-4228
  - Individual, Family, Couples, Group Counseling
  - Play therapy, art therapy
  - EMDR, trauma therapy, domestic violence classes, substance abuse counseling

- Real life Counseling, Inc.
  - Provides individual counseling to children, adolescents, and adults in the following areas: Domestic Violence, Anger Management, Substance Abuse, Marriage/Relationships, Guardianships, Grief/loss, Pain Management, Depression, and Anxiety
  - Gregory Gast, LMHC, NCC-850-271-8258
  - Office located at 3295 Crawfordville Highway, Crawfordville, FL 32327

Helplines and Hotlines

- **Apalachee Center Mobile Crisis Response Team Hotline 1 (800) 342-0774**
- **2-1-1 Big Bend**
  - **24-hour counseling, suicide prevention, community information and referrals**
  - **Dial 2-1-1 or 850-617-6333--For TTY (Hearing/Speech Impaired) dial 850-921-4020**
- **Family Health line**
  - **Information, referrals, and counseling on prenatal, infants, children and family planning**
  - **Toll Free in Florida---800-451-2229**
- **National Suicide Prevention Hotline**
  - **24-hour suicide prevention and mental health counseling**
  - **800-273-TALK (8255)**
- **Parent Help Line**
  - **Information, referrals and counseling for parents**
  - **Toll Free in Florida---800-352-5683**

- **Suicide Text Line: 741741**

- **The Trevor Project – LGBTQ+ 24/7 Hotline 866-488-7386 www.thetrevorproject.org**

COMMUNITY WELLNESS
Counseling & Support Services

REFERRAL FORM

Thank you for choosing to make a referral to CWCSS. It is our highest compliment of trust. CWCSS will continue to update you as services progress. If you require additional assistance, please call (850) 643-1033 and ask for the Referral Coordinator.

Date:	Referral Source:	Contact Number:
	Organization:	Email Address:
Have you contacted the client and/or legal guardian about your concerns and this referral to CWCSS? Y N		

Client Legal Name:	Preferred Name:	DOB:	Gender:
Address:	City & Zip Code:	SSN (for insurance purposes only):	Race:
Home Phone:	Cell Phone:	Email:	
Legal Guardian (if applicable):		Relationship:	
Emergency Contact:		Relationship:	

Insurance:	Member ID#:	Effective Date:

Reason for Referral/Concern (include any preferences):

Services Requested (Check all that apply):

☐ Individual Therapy	☐ Family Therapy	☐ Group Therapy	☐ Psychiatric Evaluation
☐ ADHD Evaluation	☐ Domestic Violence Issues	☐ Anger Management	☐ Medication Management
☐ Play Therapy	☐ Parenting Classes	☐ Grief Therapy	☐ Targeted Case Management
☐ Infant Mental Health	☐ Supervised Visitation	☐ Substance Abuse	

Are services mandated by court? Y N If so, please provide an email or fax number:

Preference for service location: ☐Home ☐ Office ☐ Telemedicine ☐ School: _____

When is client available for sessions, please list multiple times/days?

10611 NW SR 20 Bristol, FL 32321
P: 850.643.1033 F: 850.643.5066

CCYS
GUIDANCE | SHELTER | SUPPORT

CCYS Family Place Referral Form

CCYS Family Place provides individual, family, and group counseling services to youth ages 6-17. Services are free and counselors can provide up to 12 sessions of counseling. Please provide as much known information possible below to better assist matching your family with a counselor.

Demographic Information

Youth Name: _____ **DOB:**_____ **Age:**_____

Sex *(circle one):* Male Female Transgender Gender-Nonconforming Other:_____

Race (circle one): American Indian Alaskan Native Asian Black White Multiracial Other

Ethnicity (circle one): Non-Hispanic Hispanic Other:_____

Sexual Orientation: Heterosexual Gay Lesbian Bisexual Other: _____

Address (Street): _____

City/State/ZIP/County:_____

School/Grade:_____ **Special Needs?:** _____

Parent/Guardian Information

Name:_____ **Relationship:**_____

Phone (Cell/Home/Work): _____

Presenting Problems

Circle as Many as Apply: Anger School Issues Substance Abuse Eating/Sleeping Problems Truancy Depression Anxiety Beyond Control Peer Issues Grief/Loss Divorce/Blended Family Aggression Running Away Self-Harm/Suicide, Other: _____

Additional Information For Items Circled Above: _____

Referral Source: _____ **Phone:**_____

Please ensure the family has been notified of the referral before sending

Fax to 850-576-2580 or email to Ashley.mollema@ccys.org

Camelot Community Care, Inc.
Referral Form Office Ph: 850 561-8060

Date of Referral ☐Emergency Referral Referral Agency: _____

**Referral Source: Name _____ Title _____

Phone _____ Fax _____ Email _____

Client's Legal Name _____

Client's Parent/Legal Guardian _____ Who does the Client live with? _____

Home Phone: _____ Cell Phone: _____

Physical Address _____ Apt # _____

City _____ State _____ Zip _____ County _____

Mailing Address ☐Same as above

Street: _____ Apt # _____

City _____ State _____ Zip _____ County _____

Date of Birth _____ Gender: ☐Male ☐Female

Race: ☐Alaskan Native ☐Asian ☐Black/African American ☐Native American Indian

☐Native Hawaiian or other Pacific Islander ☐White ☐Unknown

Ethnicity: ☐Cuban ☐Hispanic ☐Mexican ☐Other Specific Hispanic ☐Puerto Rican ☐Unknown

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Primary Language: ☐English ☐Creole ☐Spanish ☐French ☐German ☐Mandarin ☐Portuguese

Second Language: ☐English ☐Creole ☐Spanish ☐French ☐German ☐Mandarin ☐Portuguese

Needs an Interpreter? ☐Yes ☐No

Military Status: ☐None ☐Active Duty ☐Discharged ☐Disabled Veteran

Social Security Number: _____ If none, explain: _____

Employment Status:

☐Student ☐Engaged in Residential/Hospitalization ☐Full Time Employed ☐Part-time Employed
☐Homemaker ☐Inmate of Jail/Prison/Corrections ☐Retired ☐Sheltered Employment ☐Disabled
☐Volunteer ☐Unemployed but actively looking for work ☐Other/Not in Labor Force ☐Unknown

Occupation: _____ Job Title: _____ Days worked in the past 30 days: ____

Education Level:

Highest Level Completed: ☐Elementary ☐Middle/Junior High ☐High School ☐Not School Age

Comments: Name of School _____

Education Type: ☐SED ☐EH ☐Varying Exceptionalities ☐Regular Education

☐Vocational/Job Training, If yes, for how long? ☐In 6 Months ☐In 30 days ☐Unknown

Current Medications: _____

Allergies: _____

Camelot Community Care, Inc.
Referral Form

***Behavioral Concerns per Client, Family or Referral Source** (Mark "H" if issue(s) are historical (over 6 months) and "C" if issue(s) are current); **Indicate ALL that apply:**

Abuse
__Victim of Type:
__Physical
__Emotional
__Sexual
__Excessive Corporal Punishment
__Neglect

__Perpetrator of Type:
__Physical
__Sexual

Anxiety
__Excessive Worry
__Restlessness
__Autonomic Hyperactivity
__Hypervigilance
__Specific Fear_____
__Sleep Disturbance

__Phobia_____
__Obsessive/Compulsive
_____

Self Harmful
__Cutting
__Burning
_____

Psychotic
__ Hallucinations: __A __V
__ Paranoid thinking
__ Delusions

Attention Deficit/Hyperactivity
__Short Attention Span
__Inattentive
__Impulsive
__Easily Distracted
__Failure to Follow through
__Excessive Talking
__Restlessness
__Difficulty Waiting
__Negative Attention Seeking Behaviors
__Risk Taker
__Projecting Blame
__Low Self Esteem
__Poor Social Skills

__Low Frustration Tolerance
__Enuresis
__Encopresis
__Hx of Failure to Thrive
__Fire Setting
__Fire Play
__Gang Association
__Manipulative/Lying
__Learning Disability

Post Traumatic Stress
__Decreased concentration
__"Flashbacks"
__Avoidance of issue
__Vigilance
__Sleep Disturbances
__Recurrent nightmares

Eating Disorder
__Self-Induced Vomiting
__Use of Laxatives
__Refusal to Maintain Healthy Weight
__Preoccupation w/Body Image
__Irrational Fear of Becoming Overweight

Sexually Inappropriate Behavior
__Touching
__Exposing

Poor Verbal Skills
__Expressive
__Receptive

__Pregnancy
__Physical/Medical Issues
_____

Depression
__Sad/Flat Affect
__Irritability
__Isolative/Withdrawn
__Reduced Appetite
__Sleep Disturbances
__Unresolved Grief
__Feeling Hopeless
__Hygiene Problems
__Inactive/low motivation
__Excessive Crying

__Runaway #_____

__Mood Disruption

Oppositional Defiant
__Hostile Towards Adults
__Temper Tantrums
__Constant Arguing w/Adults
__Refusing to Comply
__Blaming Others
__Demanding
__Verbal Aggression/ swearing

Conduct Disorder
__Failure to Comply
__Fighting/Assaultive
__Homicidal
__Intimidation
__Harmful to Animals
__Stealing
__School Maladjustment
__Conflict with Authority
__Risk Taking
__Blaming Others
__Little/No Remorse
__Destruction of Property

Substance Abuse
__Drugs_____
__Alcohol_____

__Suicidal Attempt #_____
__Suicidal Ideation #_____
__Suicidal Gestures#_____

***Family Circumstances:**
__Substance Use/Abuse
__Child Custody Issues
__Incarceration
__Domestic Violence
__Low Intellect of Caretaker
__Lack of parental control and/or supervision

☐ None Identified
__Financial Issues
__Marital Issues
__Resistant to Treatment
__Single Parent
__Non-English Speaking
__Lack of knowledge of child development and behavior

__Termination of Parental Rights
__Transportation Issues
__Unemployment
__Threatening Hostile Behaviors
__Family history of abuse
__Family history of neglect

__Unwanted Pregnancy
__Ineffective Parenting Skills
__Significant Medical Problems
__Poor communication and/or interactions
__Other_____

Handicaps/Disabilities at Time of Referral: ☐None at Referral

☐Autistic
☐Physically Impaired
☐Emotionally Disturbed
☐MR/Developmentally Delayed
☐Other_____

☐Hearing Impaired
☐Deaf
☐Learning Disability
☐Visual Impairment

☐Blind
☐Language Impaired
☐Traumatic Brain Injury
☐Health Impaired

☐Speech Impaired
☐Functional Delay
☐Multi-Handicapped

Household Information: (FFT Program ONLY)

Annual Household Income: $_____Individuals in your Household: _____ Individuals under 18 in your household: _____

Principal Income Source: ☐ Employment ☐ Family/Relative ☐Alimony ☐Child Support ☐ Savings/Investment

PLEASE PRINT

FLORIDA
Therapy Services, Inc.

Florida Therapy Services Referral Form

Centralized Referrals Department
850-215-1946 877-234-5351
FAX: 850-215-1942 Email: referrals@flatherapy.com

Date of referral: _____ Client Insurance Information:

Insurance type: _____ ☐ Medicaid ☐ Medicare ☐ Third Party ☐ Self-Pay

Primary Insurance #: _____ Secondary Insurance #: _____

Client Name: _____ DOB: _____ Gender: _____ SSN: _____

Client Contact Information: Phone: (primary) _____ (secondary) _____

Address: _____ County: _____
Street City State Zip

Leave message? ☐ No ☐ Yes: _____ Email Address: _____

For minors, legal guardian(s) name/relationship: _____

- ✓ Legal documents supporting guardianship/ POA? ☐ N/A ☐ No ☐ Yes: _____
- ✓ Any other legal guardians? ☐ N/A ☐ No ☐ Yes: _____
- ✓ Specific custody agreements? _____
- ✓ School: _____ County: _____ Grade: _____ ESE? ☐ No ☐ Yes
  IEP? ☐ No ☐ Yes

Referred by: _____ Referral Address: _____

Referral Phone: _____ FAX: _____ Email: _____

- ✓ Do you wish to be updated on the status of this referral? ☐ No ☐ Yes
- ✓ Do you have any specific requests regarding this referral? ☐ No ☐ Yes
- ✓ *If yes, explain:* _____

Reason for referral: _____

Is the client reporting that they are a danger to themselves or others? ☐ No ☐ Yes

- ✓ *If yes, explain:* _____

Substance abuse issues/ concerns reported? ☐ No ☐ Yes

- ✓ *If yes, explain:* _____

Has the client received mental health services at FTS or elsewhere in the past? ☐ No ☐ Yes

- ✓ *If yes, when and where:* _____
- ✓ *Previous diagnosis?* _____

DISC Village

Parent/Guardian Permission Letter to Join New Horizons

I certify that I am lhe Parent/Legal Guardian of the above mention student and I hereby grant permission for my child to join the New Horizons program.

I understand my child will be attending 12 or more small-group sessions or lndMdual visits.

Topics will Include:

- Self-esteem
- Decision-making
- Anger management
- Coping sklllls
- Positive relationships
- Communication skills
- Personal responsibility
- Dangers *of* alcohol, tobacco and other drugs

Program Goal:

To help students make constructive choices so *they may Increase positive and responsible behavior both at chool and in the community.*

Your chird will meet with this school's **assigned Prevention Specialist from DISC Village** at least **one time each week** ov r lunch or during an elective period (with the exception of test days). Should my child miss any work, he/she will need to make it up. The New Horizons Program also offers in-school tutoring.

X

Parent/Guardian Signature ***Date***

Prevention Speclallst Signature/Credentials ***Date***

Print Name

Print Name

Health and Wellness Services:
3333 West Pensacola Street
Tallahassee, FL 32304
Telephone: (850) 574-6240
FAX: (850) 576-3317
www.discvillage.org

disc village
Over 40 years of prevention, intervention & treatment services

New Horizons Referral Form

Student's Name:_____ Grade:_____

Person Referring:_____ Date:_____

Check (✔) all that apply

- ☐ Suspected use of alcohol, tobacco, and/or other drugs
- ☐ Poor Communication
- ☐ Poor Decision-Making Skills
- ☐ Easily Agitated
- ☐ Anger Issues
- ☐ Depression
- ☐ Suicide Ideation
- ☐ Anxiety
- ☐ Emotional Regulation
- ☐ Grief
- ☐ Behavioral Issues
- ☐ Family Issues/Struggles
- ☐ Self-Esteem
- ☐ Trauma
- ☐ Failing grades

Comments or other observed behaviors: _____

_____

_____

_____

_____

To be completed by Health and Wellness Specialists

Follow-up completed ☐ Yes ___/___/___ ☐ No (*explain*): _____

Recommended Services

☐ No services recommended at this time

☐ Services: _____

_____ _____ _____ _____

Health and Wellness Specialists Signature/Credentials | Date | Student Signature | Date

1723 Mahan Center Blvd.
Tallahassee, FL 32308

BEREAVEMENT SUPPORT REGISTRATION FORM
-YOUTH-

(850) 878-5310
www.bigbendhospice.org

GENERAL INFORMATION

CHILD'S SCHOOL/AGENCY

CHILD'S TEACHER/COUNSELOR

BBH COUNSELOR

Is this your first time your child is receiving grief support following their loss? ☐ Yes ☐ No

PERSONAL INFORMATION

CHILD'S FULL NAME | AGE | DATE OF BIRTH

YOUR NAME | RELATIONSHIP TO CHILD

ADDRESS | CITY | STATE | ZIPCODE

COUNTY

PREFERRED PHONE NUMBER | EMAIL ADDRESS

INFORMATION ABOUT THE PERSON WHO DIED

NAME OF THE PERSON WHO DIED | RELATIONSHIP TO CHILD

DATE OF DEATH

Cause of death if known *(check one)* ☐ Natural/Illness ☐ Accidental ☐ Suicide ☐ Homicide

Does your child know the true cause of death? ☐ Yes ☐ No

With whom does your child currently live? ☐ Parent(s) ☐ Sibling ☐ Relative ☐ Other

Child receives primary emotional support from?
☐ Parent(s) ☐ Sibling ☐ Relative ☐ Mental Health Practitioner ☐ Clergy ☐ Other

Is your child experiencing any of the following behaviors since the death? *(check all that apply)*

☐ Withdrawal	☐ Anger	☐ Loss of interest in life
☐ Difficulties at school	☐ Change in sleep patterns	☐ Change in friends or social life
☐ Change in eating habits	☐ Talks about suicide	☐ Talks about hurt themselves or others

Is there anything else you would like for the group leaders to know about your child and their loss?

CONSENT FOR GROUP PARTICIPATION

I consent to my child or teen participating in the school-based grief support group. The group will meet for approximately 45-60 minutes once a week for six to eight weeks on school grounds. I understand that my child or teen is responsible for all work missed as a result of their participation in group. If I have questions or concerns regarding the group, or my child's grief process, I can contact a Big Bend Hospice staff person at (850) 878-5310.

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

CONSENT FOR INDIVIDUAL GRIEF COUNSELING

I consent to my child or teen participating in school-based individual grief support counseling. Three to four individual counseling sessions lasting a duration of approximately 45-60 minutes are available on school grounds. I understand that my child or teen is responsible for all work missed as a result of their participation in counseling sessions. If I have questions or concerns regarding the grief support counseling or my child's grief process, I can contact a Big Bend Hospice staff person at (850) 878-5310.

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

OPTIONAL INFORMATION *(FOR STATISTICAL PURPOSES ONLY)*

Your child's gender

Race ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Native American ☐ Other_____

How did you hear about the group?

Big Bend Hospice
your hometown hospice, licensed since 1983
1723 Mahan Center Blvd. Tallahassee, FL 32308
(850)878-5310 • 1-800-772-5862 • info@bigbendhospice.org
WWW.BIGBENDHOSPICE.ORG

Big Bend Hospice Confidentiality and Counseling Agreement

CONFIDENTIALITY

I (parent or guardian if appropriate), _____understand that, although Big Bend Hospice values and maintains confidentiality for each client who enters counseling, there are certain circumstances in which confidentiality cannot be maintained. The following are such circumstances:

1) In the event of possible suicide or homicide, professionals, family members or other persons directly involved may be notified without the permission of the client, if the client of another person(s) is in life-threatening danger or crisis.

2) If a client reports being a perpetrator of physical, emotional, or sexual abuse towards a child, disabled person or elderly person, or if a client reports immediate knowledge of such abuses by another person, the counselor is required by law to immediately report such information to the proper agency with or without the client's permission.

3) A counselor may discuss a client with a clinical supervisor or clinical team. I understand that in all other circumstances, I must sign a release of information form in order to give permission to reveal that I am receiving counseling and to discuss involving my treatment with any other person or agency.

4) In the event of an emergency, minimal information would be provided to first responders.

☐ I acknowledge receipt of a copy of Big Bend Hospice Notice of Privacy Practices.

COUNSELING

I, (Parent or guardian, if appropriate), _____ give Big Bend Hospice permission to provide bereavement counseling to _____.

I agree to attend my appointments as scheduled. If I need to cancel an appointment, I will do my best to contact my counselor or Big Bend Hospice at 878-5310 and let them know. I understand that if I miss multiple appointments, Big Bend Hospice reserves the right to discontinue counseling and will refer me to another provider.

Client: _____Date: _____

Parent or guardian, if applicable: _____Date: _____

Big Bend Hospice

your hometown hospice, licensed since 1983

Apalachec: Center, Inc.

Wakulla School Referral Form

Date: I '___

Student's name ---------- Gradelevel:_ _

DOB_____SSN._____Jnsurance:Yes_ No_ Medicaid_

Nameofthe School where student isenrolled:_____

Diagnosis: (if known)
Axisl(Primary):_____
Axis l(Secondary): _____
Axisfi:_____
AxisDl:_____ ---= ---
AxisIV:_____AxisV(COAS):____

Reason(s) for the referrai (Including cwrent level of insight, recommendations, and any other particular concern/behavior issues):

Wasstudent informed of this referral? Yrs No
lf yes, was the student agreeable to receiving servi ? _ Yes _ No
Was student lepl guardian (i.e. parents) informedofthisrefcrral? _Yes _No
lfyrs, wos the legal guardian agreeable to receivmg·services? Yes_ No

Completed by: _____ _'__'__

StaffNeme Title/Credential Date

Student's SignatlU'e: _____

Legal Ouardian's Signature: _____

Legal Ouardian's contacl information: _____

A TIME TO CHANGE
COUNSELING CENTER, P.A.

2140-B Crawfordville Highway • Crawfordville, Florida 32327
1363 East Lafayette Street • Tallahassee, Florida 32301
Telephone: (850) 926-1900 • Fax: (850) 926-1930

REFERRAL FORM

Date of Referral: _____

Client Name: _____ Preferred Name: _____

Date of Birth: _____ Age: _____ Gender: Male Female

Address: _____

Home #: _____ Mobile # _____

Email Address: _____

Parent/Guardian/Spouse: _____

Referral Source: _____

Name & Title of Person _____

Phone #: _____ Fax #: _____

Relation to Client: _____

Insurance: Yes No If Yes, Name of Carrier: _____

Policy Holder's Name: _____

Policy/Member ID: _____ Policy Group #: _____

Presenting Issues:

_____

_____

_____

For ATTCCC Office Use:

Date of Consultation: _____ Therapist Assigned: _____

Coastal Rehabilitation and Treatment Services

Referral Summary

Name: _____

Address: _____

Phone Number: _____ Email: _____

Date of Birth: _____ Social Security#: _____

Insurance Infonnation: _____

Primary Care Physician: _____

Presenting Problem: _____

_____

_____

_____

_____

Current Services in Place: _____

_____

_____

Reports to be made to: _____

_____

Immediate
Risk: _____

Request for Services to include: _____

_____

_____

Referral Date: _____

Referrals can be made to: Fax: (850)697-3891
Phone: (850)566-0037 Email: coastalrehabservices@gmail.com

-

Referral Form for Mental Health Services

Oient Information:-

Name:_____ Date of Birth:_____ Race/Ethnicity:.___ _

Gender: Male Female School& Grade:_____

ContactNumbers:._____ MessagesOk? Yes No

Address: _____

Parent or Legal **Guardian Information:**

NameofParentorLegalGuardian: _____

Contact Numbers:_____

Address: _____

Type of Insurance: _____

Insurance ID# ---------- Group#:_____

Child's current Mental Health Information:

Current Medication:,_____

Current Diagnosis:._____

Real Life Counseling, Inc.

Gregory E. Gast, MS, LMHC, NCC
3295 Crawfordvllfe Hwy. Suite 4 Crawfordvllfe,Florida 32327
Phone: (8S0) 271•8258 Fax: (850) 926-529S Email: gregmha1@gmall.com

current Mental Health Symptoms:	Unknown	Not Present	MIid	Moderate	Severe
Hallucinatlons (Describe)					
Deluslons·					
Thought Disorder					
Biiarre Behavior (Psychotic)					
Anxiety/ Nervousness					
Obsessive/ Compulslve					
Phobias/ Fears					
Depressed Mood					
Mood Swings					
Sleep Disturbance					
Irritability					
Anger/ Temper Tantrums					
Hyperactivity					
Attention Deficits					
Eating Problems					
Elimination Problems					
Oppositional/ Defiant Behaviors					
Antisocial/ DelinqiJent or Conduct Disorder					
Over Sexualiied Behavior					
Somatic Complalnts with no Known Medical					
Attachment Disorder					
Other (Explain)					

Real Life Counseling, Inc.

Gregory E. Gast, MS, LMHC, NCC

3295 Crawfordville Hwy. Suite 4 Crawfordville,Florida 32327

Phone: (850) 271-8258 Fa>e **(850)** 926-S295 Email: gresmha1@gmaH.com

APALACHEE CENTER

CAT Referral Form

Youth Information

Name: _____ DOB: _____

Gender: _____ SSN: _____

Phone #: _____ Insurance: ☐ CHP ☐ BCBS ☐ Other: _____

Address: _____

Main Language(s): ☐ English ☐ Spanish ☐ Creole/French ☐ Other: Translation needed? ☐ Yes ☐ No

The individual referred and the family were notified: ☐ Yes ☐ No

Parent/Guardian Information

Parent or Guardian Name: _____ Phone: _____

Check All That Apply:

☐ This youth has a documented mental health diagnosis: ☐ Unsure

Diagnoses: _____

_____

_____

Current Medications: _____

_____

_____

_____

☐ This youth has had at least one of the following:

- ☐ Repeated "traditional" treatment failures or in treatment with no progress/worsening
- ☐ Recent history of crisis stabilization unit or psychiatric hospital admissions
- ☐ Alternative school placement or at risk of "dropping out"
- ☐ Returning home from a residential treatment facility
- ☐ In foster care, but working toward reunification or adoption or at risk of going into foster care/shelter care
- ☐ At risk of being placed in a Department of Juvenile Justice residential commitment program
- ☐ Other: _____

☐ This youth has family that is willing to work with the CAT Team. Collateral included?

☐ This youth has other providers currently working with the family. ☐ Yes ☐ No

Whom? _____

Reason for CAT Team Referral (Please explain why
increased level of care including current and previous

_____

_____

_____

_____

_____

**Indicate ALL other services the referred individual
programs and outcomes as well as all hospitalizati**

Name of Provider/Place:	

Referrer Information

Name: _____

Address: _____

Relationship to youth: _____

Forward Completed Referrals To:

Community Action Team

2634 Capital Circle NE Building B

Tallahassee, Florida 32308

***** PLEASE INCLUDE COLLATERAL INFORMAT
records, psych**

***PLEASE NOTE THAT ADDITIONAL INFOR
ELIGIBILITY FOR CAT TEAM SERVICES. PI**