FAMILY CENTER APPLICATION

Eligibility Criteria

☐ The child must be at least 5 but not older than 18.

☐ The child is a resident of Nassau County.

☐ The child must have a Serious Emotional Disturbance: DSM mental illness diagnosis (excluding substance disorders, organic brain syndromes, developmental disabilities and social V code conditions), AND has experienced functional limitations due to emotional disturbance over the past 12 months on a continuous or intermittent basis. These limitations must be moderate in at least 2 or severe in at least 1 of the following areas: ability to care for self, family life, social relationships, self-direction/self-control, and ability to learn.

Required Attachments:

☐ Psychiatric (completed within past 12 months)

☐ Psychosocial (completed within past 6 months *or* 12 months with an addendum within past 3 months)

☐ *Psychological only required if IQ is below 70* (completed within past 3 years)

Note: *SPOA Applications completed within the past 6 months may be used in place of this application. To do this, complete & attach only this page to the SPOA Application. For all others, please skip the box below and complete the remainder of the application.

Application Being Used:

☐ Family Center

☐ SPOA

ONLY COMPLETE THIS SECTION IF A SPOA APPLICATION WILL BE USED TO APPLY
Child's Name:
Date of Referral:
SPOA Program: ☐ICM ☐SCM ☐CCSI ☐CCCT ☐HCBS ☐Unknown
Referral Source
Name:
Agency & Program:
Address:
Phone:
☐ **I, guardian of the above child, authorize the SPOA Application to be used to apply to Family Center** _____ *Parent Signature / Date*:

Please forward completed applications to:
Christine Miller, LMSW, Director
400 Oak Street, Suite 104, NY, 11530
(P) 516-485-5976 x 3259 (F) 516-565-6095 (E) Cmiller@familyandchildrens.org

Family & Children's Association
Family Center Application

Child's Name:		DOB:	☐Male ☐Female
Child's Primary Language:		Ethnicity:	
Child is residing with: ☐Biological parent(s) ☐Foster parent(s) ☐Adoptive parent(s) ☐Other:			
Reason for referral:			
Guardian's Name:		Family's Primary Language:	
Address:			
Home #:		Cell #:	
Work #:		Other #:	
Educational			
School's Name:		Is the child currently attending ☐Yes ☐No	
Grade:	CSE Classification:	IQ Score:	IQ Test Date:
Diagnoses			
Axis 1:			
Axis II:			
Axis III:			
Axis IV:			
Axis V/GAF:			

Medications ☐*N/A None Prescribed*			
Type	Frequency	Type	Frequency

History of Out of Home Placements and/or Psychiatric Hospitalizations ☐*N/A None Reported*		
Facility Name	Date From	Date To

Child's Name:	DOB:	☐Male ☐Female

Areas of Need:
To qualify, the child must have either moderate in at least 2 or severe in at least 1 of **the first 5 areas.*

Area	Not Evident	Mild	Moderate	Severe	Specify *Required for moderate & severe*
**Ability to Care for Self*	☐	☐	☐	☐	
**Family Life*	☐	☐	☐	☐	
**Social Relationships*	☐	☐	☐	☐	
**Self-Direction /Self-Control*	☐	☐	☐	☐	
**Ability to Learn*	☐	☐	☐	☐	
Suicidal Ideation	☐	☐	☐	☐	
Psychosis	☐	☐	☐	☐	
Depression	☐	☐	☐	☐	
Anxiety	☐	☐	☐	☐	
Sexually Inappropriate	☐	☐	☐	☐	
Verbal Aggression	☐	☐	☐	☐	
Physical Aggression	☐	☐	☐	☐	
Fire Setting	☐	☐	☐	☐	
Animal Abuse	☐	☐	☐	☐	
Substance Abuse	☐	☐	☐	☐	

Treatment & Service Providers
Add additional providers below. Enter N/A if any listed providers are not involved.

Service Type	Agency, Program & Worker	Address & Phone
Referral Source		
Therapist		
Medication Management		
SPOA Program		

Signatures

_____ *Referral Signature / Date*:	_____ *Parent Signature / Date*:

Complete: Client Name, Date, From/To, Authorization Expiration, and Signatures

AUTHORIZATION

for RELEASE of
CONFIDENTIAL INFORMATION

Family and Children's Association
100 East Old Country Road
Mineola, New York 11501

Rev. 4/2/04

CLIENT'S NAME: DATE:

PROGRAM NAME: **The Family Center**

List the specific topics to be shared and the purpose for sharing this information, plus restrictions, if any:

Telephone contact and/or written summary for the following: Family Center Application, Psychiatric Assessment, Psychosocial Assessment, Psychological Assessment, Physical Assessment, Treatment Plan, Educational Assessments, and any other relevant clinical data.

Specify the Persons/Agencies authorized to Use and/or Disclose* this information:
*[Use "**From**" and "**To**" to indicate one-way disclosure from one source to specified recipient(s)]*

To/From:

Family & Children's Association

Family Center Program

400 Oak Street, Suite 104, Garden City, NY 11530

From/To:

I understand that my records are protected under Federal Confidentiality Regulations (or other state and/or local statutes/regulations) and cannot be given out to anyone without my written authorization. I also understand that I may revoke this authorization at any time – except to the extent that some or all of the information originally authorized to be released has already been disclosed. I further understand that treatment is not conditional upon authorizing release of PHI.

This authorization will automatically expire (check one):

☐ Upon discharge from the program; ☐ Other date (not to exceed one year): _____

_____
Client's signature & Date

_____ _____
Parent or Guardian signature (if necessary) & Date Print Parent or Guardian name

_____ _____
Witness signature & Date Print Witness name

***NOTICE TO RECIPIENT REGARDING REDISCLOSURE OF CONFIDENTIAL INFORMATION:** This information has been disclosed to you from confidential records that are protected by state and federal law. These laws prohibit you from any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of state and federal law may result in a fine, jail sentence, or both. A general authorization for the release of medical or other information is NOT sufficient authorization for further disclosure.