North Star Behavioral Health Services
Enhanced Mentor Program
Referral Application

Please send all referrals to: **Enhanced Mentor Program**
Kimberly Lackner
70 Edgewood P.O. Box 1270
Saranac Lake, NY 12983
Fax (518) 891-2621
If you have any questions, please call (518) 891-2510 or email Kimberly at kimberlylackner@citizenadvocates.net

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Referral for: (Check all that apply)

One-on-one Mentoring Services: ____ After School Program: _____ Summer Youth Program: ______

Personal Information:

Child's Name (Last, First, Middle Initial): ______________________________

Date of Referral: __________________

Date of Birth: __________________ Gender: ____________

Current Address: ______________________________

Parent/Guardian Name: __________________________

Primary Telephone: ________________________ Alternate Telephone: ___________________________

Person making the referral: ____________________________ Relationship to Child: ____________________

Telephone: __________________________________

Please include a signed Parent Consent for Referral Form, which can be found attached to this referral.

School Placement: ________________________________ Grade: ___________________________

Teacher/Contact: ________________________________ Telephone: _________________________

Is child CSE classified? Yes____ No____ If yes, in what area(s): ______________________________

Reason for referral (presenting behavior): ______________________________

Mental Health Information: (A diagnosis, or lack thereof, does not qualify nor disqualify a child for Mentor referral. This is simply helpful information protected under the HIPAA Privacy Act.)
Psychiatric Diagnosis: ______________________________

Psychiatric Medications: ______________________________

Provider(s) involved (past and present, i.e. ICM, SCM, DSS, Mental Health, Probation):

____

Has the child recently had a Wrap Around meeting? Yes _____ No _____
If yes, please provide dates: ______________________________

List child's personal interests/hobbies:

____

List specific strategies the Mentor might use to assist the child (talking, reading, games, etc.):

____

____

Additional Comments: ______________________________

____

For Manager's Use Only: **Date Received:** ____________
Name of Mentor: ______________________________
Date of Initial Contact: ____________ **Match Date:** ____________ **Screen Date:** ____________

Updated: 8/8/18

North Star Behavioral Health Services
Enhanced Mentor Program

Eligibility Criteria

___ **Franklin County Resident**

Grade Level

__ Kindergarten
__ 1st
__ 2nd
__ 3rd
__ 4th
__ 5th

AND

I. __ Severely Emotionally Disabled (SED) ****automatic eligibility**

II. Must meet *one* of the following

__ At risk for out of home placement
__ Involved with the Legal system – PINS or Probation
__ DSM-5 Diagnosis – ADD, ADHD, Conduct Disorder, ODD, Bipolar, PTSD, or Manic Depression
__ Recommended by the Coordinator of Children's Services Initiatives (CCSI) Tier I or Tier II Process
__ Committee on Special Education Classified (CSE) – Emotionally Disturbed

OR

III. Must meet *two* of the following:

__ Poor school performance
__ Poor school attendance
__ Unprepared for class
__ Does not participate in class
__ Aggressive behavior in school
__ Frequent trips to the principal's office
__ Trouble relating to peers and adults
__ Lack of motivation
__ Poor communication
__ Isolative behavior
__ Single parent home
__ Death of a close family member
__ Substance abuse (child/caregiver)
__ Poor self-esteem
__ CSE classified (any area)

______________________________ ______________

Signature of staff verifying above Eligibility Date

Updated: 8/8/18

AUTHORIZATION FOR RELEASE OF INFORMATION

North Star Community Support Services
A Division of Citizen Advocates, Inc.
70 Edgewood Rd, Saranac Lake, NY 12983
Phone#: (518) 891-5535 Fax#: (518) 891-5851

Client Name (PRINT)____ DOB:______________
***I may refuse to sign this authorization. I understand that treatment/services, payment, or eligibility for benefits may not be conditioned on my providing an authorization for the use or disclosure of protected health information.**

A separate form is required for each person or agency.

I hereby give my authorization to _______ release information to, and/or _______ release information from

Agency or Individual: ____

Program/Unit of Service/Relationship (if applicable): ____

Address:____
 # Street City State Zip Code Telephone

The minimally necessary information to be used or disclosed:	Yes	No
Assessment, diagnostic, discharge reports.		
Treatment/service goals, progress, recommendations.		
Medications.		
Information about alcohol and/or other drug use.		
Court or probation records.		

**The information to be released pertains to my medical/health records
from (insert dates) ____________to _____________** (When relevant)
Other and/or restrictions:

Note: Psychotherapy or individual service notes will not be released without specific authorization.

This information disclosure is necessary: ____ To assist in assessment of service needs _____ To coordinate provider services

_____ To permit discharge planning _______ At individual's request

I authorize disclosure of my protected health information to the person/agency specified, for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed and the recipient(s) of the information. I understand that redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part. I further understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form. Revocation will be effective upon the date the notice is received. Revocation does not apply to information furnished before that date.

This authorization (check one): _____ Is for a one-time release _____ Will expire on ____/____/______

Will expire_____ 90 days following discharge from program: _______________________________(90 Day Expiration Date: ____/____/_____

____When this condition is fulfilled: ______________________________

Redisclosure of record information to other parties is prohibited. This authorization applies to information which may contain reference to drug/alcohol treatment, in accordance with Federal Regulations 42 CFR, Section 2, and 45 CFR 160 and 164 (HIPAA).

Client Signature:____ Date: ____/____/______

Parent/Guardian Signature: :__________________________________ Date: ____/____/______

Citizen Advocates Staff Signature: :____________________________ Date: ____/____/______

Print Staff Name and Program Title:____

– complete routing instructions reverse side –

INSTRUCTION: SEND/RETAIN THE ORIGINAL FORM FOR THE PERSON OR AGENCY WHO IS RELEASING INFORMATION. COPY BOTH SIDES OF FORM FOR RECORD RETENTION BEFORE MAILING THE ORIGINAL.

Provider Instruction:	Signature:	Date:
____ **File Original in Client Record for Later Use**	______________________________	___/___/___
____ **Mail Original to Information Source/Copy to Record**	______________________________	___/___/___

Additional Instructions (specify documents or information to be provided and/or excluded):

Office Use (specify each time information is released and identify contents):

Date Sent: **Method of Transmission:** **Initials:**
Information Provided:

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REVOCATION SECTION:

I hereby revoke this authorization.

Client Signature:____ **Date:**_____/_____/_____

____ **Date:**_____/_____/_____
Parent/Guardian Signature (if client is a minor or incapacitated)

Witness Signature:____ **Date:**_____/_____/_____