



Summit Family &
Children First Council

Service Coordination Plan July 2010

INTENT OF THIS DOCUMENT

This county Service Coordination Plan shall serve as the guiding document for coordination of services in Summit County when a child/youth with complex, multi-system needs is referred to the Summit County Family & Children First Council for assistance as required in Ohio Revised Code (ORC) 121.37 and 121.38.

For those children who also receive services under the Help Me Grow program, the service coordination mechanism shall be consistent with rules adopted by the Department of Health under section 3701.61 of the Revised Code.

DEFINITION OF SERVICE COORDINATION PLAN & SERVICE COORDINATION MECHANISM

The Service Coordination Plan is the result of working in partnership with families to develop a holistic service plan that is family centered, individualized to meet the unique needs of the specific family and child, strength based and is sensitive to the family's cultural, ethnic and racial background. The Service Coordination Mechanism is the planning process that Summit County FCFC has developed working collaboratively with county agencies to develop coordination of services in the county and a process by which a child is referred to the Council for assistance. Summit County has a strong history of collaboration efforts and has a rich mix of services and supports for families. Summit County FCFC has built upon this foundation and supports existing agencies service coordination efforts. FCFC's service coordination mechanism exists for families whose multiple needs may not be met within the traditional agency systems or if the family needs assistance being linked to appropriate services and or supports. The same principles of service coordination are also utilized with FCFC's Help Me Grow Program.

APPROVAL OF SERVICE COORDINATION PLAN

The Service Coordination Plan has been approved for submission by the Summit County FCFC Executive Committee (*see July 1, 2010 minutes*). The plan was also posted on the county FCFC website for review and comments from the general membership. It was discussed and approved by the membership. (*see August 5, 2010 minutes*). The plan is posted on the Council's website at www.fcfcs Summit.org. Input will be sought by the membership for any future changes and/or additions.

The following agencies participated in the development of the Service Coordination Plan:

Summit County Children Services	Parent representative
Summit County Juvenile Court	Mental Health America
Summit County Health Department	Department of Youth Services
Help Me Grow	Akron Children's Hospital
Family & Children First Council	Akron Public Schools
Summit Development Disabilities Board	Summit County ESC
The Arc of Summit & Portage Counties	Child Guidance & Family Solutions
Summit County ADAMHS Board	

MONITORING SERVICE COORDINATION PLAN

FCFC, Help Me Grow and Summit County Cluster for Youth (Cluster) will review the plan at least yearly. The Director of FCFC is responsible for initiating the review and distributing the plan and any amendments to the FCFC membership. Several methods will be utilized to determine if the county is meeting the goals of the service coordination plan. The Self Assessment Tool will be part of the continuous improvement process and will be used to review, amend and or add articles to the plan in order to keep it current with best practice and as a tool to measure our success in meeting the goals of the plan. Since the Cluster Review Council approves Cluster cases this will also afford the opportunity for monitoring how well the plan has been transferred into actual practice. The data maintained by the Cluster Coordinators and the evaluation data and reports received from the Cluster evaluators are all tools that will be utilized to assure compliance. Cluster data is tracked in a database and a report is generated each year and provided to all FCFC and Cluster members (*see Cluster Annual report 2009*). SOC service coordination data is tracked on the FCSS tracking form and submitted to the State on at least a yearly basis or more often if requested. FCFC is also looking at developing a database to track FCSS: SOC cases so outcomes may be monitored. FCFC will comply with state guidelines for the service coordination plan and tracking requirements.

Writing the plan is the initial step but integrating this into the community fabric of services both at the administrative and at the case level is an ongoing process. The plan will become part of the yearly Cross System Training Class that the Cluster sponsors. This year long training includes 30 participants from various agencies in the community that work with children and families. This exposure will assist in integrating the plan across systems in the community. FCFC staff (Cluster coordinators) also train the 4 main referring agencies (Children Services, DD, Juvenile Court and ADAMHS board) about the service coordination mechanism approximately yearly or when requested by the agencies. Families are made knowledgeable of Summit County's service coordination through the Mental Health America PEERS program. PEERS stands for Parent Education Empowerment Resources and Supports. They have trained parent advocates and offer support groups to parents who have children with severe emotional and behavioral health needs. They are also made aware of the service coordination mechanism through the Summit County FCFC website at www.fcfcsummit.org. It should be noted that the goals, guiding principles and vision of Summit County FCFC also applies to Help Me Grow. In addition, if new parents and/or agencies become members of FCFC they will be oriented about the Service Coordination Plan and the By Laws for FCFC.

FAMILY INVOLVEMENT

Summit County partners with Mental Health America for parent advocacy. This agency has trained parents that work with FCFC and the Cluster at both the system level and the case level. They serve as parent advocates for FCSS: System of Care (SOC) cases. The director of Mental Health America and the PEERS coordinator both sit on the Cluster review council. FCFC has set aside FCSS: SOC dollars to help support parent advocates by providing stipends for attending meetings. FCFC has also provided financial support to Mental Health America to support, train, and offer professional growth for the programs advocates. All families referred for service coordination via FCSS: SOC are offered a family advocate through Mental Health America PEERS if they so choose. Parents sign a form either requesting or denying a referral for a parent advocate. If requested by the family, the SOC coordinator makes a written referral for a parent advocate.

STRUCTURAL COMPONENTS/TARGET POPULATION

Summit County's Service Coordination has two (2) levels of intervention. The first level is children/families who are referred to Service Coordination via FCSS: SOC (System of Care). These are youth who are in their own home or a home of a relative who need supportive services to be maintained in their home and/or community. There is a release of information signed by the parent/guardian and a referral form for this level of intervention. The second level of service coordination is children who are involved in 2 or more systems that may need supportive services to be maintained in their own home and/or community or who may need to be placed outside their home in a more restrictive setting for treatment reasons and the placing agency may request funding assistance from the Cluster shared pool. These are children who have typically been involved with many systems and received several services. These cases are opened as Cluster cases only with the approval of the Administrative and Review Council's approval.

Both levels of intervention/service coordination serves children birth through the age of twenty-one (21). These youth may be abused, neglected, dependent, unruly or at risk to be unruly or delinquent, youth with behavioral health needs or youth whose families are voluntarily seeking services. Summit County chooses to define the unruly population by the legal definition of status offense, "Any child who has violated a law applicable only to a child, such as truancy, curfew and runaway is considered to be a status offender". Also included in this category, are "unruly/incorrigible cases, which are defined as any child who does not submit himself to the reasonable control of this/her parents, teachers, guardian or custodian by reason of being wayward or habitually disobedient". These youth may be alleged unruly, adjudicated unruly or those at risk of becoming unruly. By definition, youth may be deemed unruly only until the age of eighteen (18).

The Cluster Service Coordination Mechanism does not usurp community agencies of their primary responsibility, mandates or expertise. The Cluster builds on the community agencies expertise but offers a cross-system expertise of how to resolve cross agency disputes, offers additional funding avenues, offers a process to build consensus between systems and between systems and parents and assist in identifying services and/or placement options in the least restrictive setting with parental input.

The implementation of the Service Coordination Mechanism is managed by Summit County Cluster for Youth (Cluster), a program under the direct supervision of the Summit County Family & Children First Council director. However, the Cluster is funded through local pooled dollars of Children Services, ADAMHS Board, Juvenile Court and the Developmental Disabilities Board.

LEVELS OF INTERVENTION

FCSS: SOC (System of Care)

System of Care (SOC) is a broad, flexible array of effective services and supports that focus on family-centered practice, community-based services, strengthening the capacity of families, and providing individualized services. SOC focuses on maintaining children and youth in their own homes and communities by providing non-clinical family-centered services and supports. It is not just a funding source but a process by which families and systems work together to identify services and supports to help strengthen the family.

The **target population** for Summit County's Service Coordination Mechanism are:

1. Children ages 0 through 21 who have complex, multiple system needs who are referred by agencies, social service systems or parents voluntarily seeking services (they do not have to be involved with a certain number of systems but may have needs of more than one system)
2. Children at-risk for out-of-home placement (residential placement, hospital, or detention center)
3. Children who need intensive community-based services

A referral to Summit County FCFC for System of Care, (SOC), service coordination may be made by any agency in Summit County, including the school system, Juvenile Court or any family voluntarily seeking services. If a family is seeking services they may contact the SOC coordinator, at any time, via telephone at 330-926-5671. They do not need to complete a referral form. The SOC coordinator will gather all pertinent information from the parent during that phone call and schedule an initial meeting with them at a time, date and location convenient for the family. The SOC coordinator will then contact all team members identified by the parent/guardian, including the child's school district of origin/attendance, via email or telephone, to schedule subsequent team meetings. If there is an agency involved with the family they are invited to the staffing as well. If an agency is making a referral they must do so by submitting a completed referral form (*see addendum A*) as well as a parent/guardian signed FCFC SOC release of information (*see addendum B*). The Referral Process, Referral Form and Release of Information can be accessed via the FCFC website at: www.fcfcsummit.org. The completed forms may be sent to Charity Hawkins via email chawkins@schd.org, regular mail at 1100 Graham Rd. Circle, Stow, Ohio 44224 or fax to 330-923-1350.

The SOC coordinator documents the date the referral was received, contacts the referent, and/or parent/guardian, within 7 days of receipt of the referral to schedule the initial team meeting. A team meeting is typically scheduled within one week, or later upon the request of the parent, at a date, time and location convenient for the parent. If the family's only need is to be referred to

another community resource this is done and the case may not be opened. All contacts, responses, outcomes of referrals, and referral for community services are documented in a contact log in each family's file. Planning is always focused on implementing a child's plan in the least restrictive setting and appropriate level of service intensity, which is typically in their own home and community but may sometimes be in the home of a friend or relative as approved by the family. If the need for other interventions can be identified prior to court involvement, services are put in place to meet those needs. Also, there will be a team meeting prior to any child being placed outside their home for treatment or within 10 days if they are placed outside their home. If a child is placed outside their home through an order by Juvenile Court, for unruliness or delinquency or Children Services due to custody, dependency, neglect or abuse, that agency may choose not to involve FCFC for service coordination and place the child and fund the placement themselves. Further system penetration is avoided whenever possible. If for any reason, needed services or supports are not available, the SOC plan will outline efforts to address such gaps.

The SOC coordinator will, with the family's approval:

- Schedule team meetings as requested by the family and/or a team member
- Facilitate each meeting
- Assist the team with assessing the family strengths, needs and culture
- Assist team with developing a plan. All services for which funds will be used must be written into the plan
- Help team develop a crisis and safety plan. If an involved agency already has a crisis and safety plan they may provide it to the team. It will be reviewed to see if anything should be added or deleted.
- Have at least monthly contact with the family or agency worker (in person or by phone), unless the family identifies a need to meet more or less frequently.

The SOC coordinator informs the parent they may invite anyone they wish to any meeting as a support person. The coordinator will contact any informal supports the family would like. They are also informed about accessing family advocacy through Mental Health America as another option for a support person. If the parent chooses to have a parent advocate, the SOC coordinator makes a written referral, via email or fax, to Mental Health America PEERS program. The parent invites the advocate to all meetings they would like them to attend.

The SOC coordinator, at the first meeting with the parent, assesses the strengths, needs and culture of the family with the parent's input (*see addendum D*). Other team members are also contacted and may have input. Summit County does not have a standardized tool for assessing the SNCD but gathers this information through discussion with the family, and other team members, and documents it on the addendum D form for the family to review. This is usually done within the first two meetings with the family. Team members sign a confidentiality agreement, at the first meeting, assuring that none of the family's personal information shared during team meetings will be shared with others outside the identified team without written consent of the family (*see addendum C*). This is done at the initial team meeting. The team then develops a family service coordination plan (*see addendum E*). Plans are written with the input of all team members, including the family, to ensure that it is responsive to their family's strengths, needs, family culture, race and ethnic group. If other public systems already have a

treatment plan, objectives from those plans are incorporated into the service coordination plan. The family has a voice and is encouraged to participate during all aspects of the plan development. They identify and prioritize their family's needs so services and supports may be accessed to meet those needs. Team members are inquired as to which tasks they are able to perform and time frames are established and documented in the service coordination plan. The family approves all aspects of the plan including who facilitates the meetings and when reviews are needed. A crisis and safety plan is developed by the team. (*see addendum F*). If a case manager on the team has already developed a crisis and safety plan, it is reviewed by the team and modified, as needed, so as to not duplicate plans or overwhelm the family. If an emergency placement takes place the SOC coordinator is notified and a team meeting is scheduled as quickly as possible within 10 days. SOC team meetings typically take place on a monthly basis but can be sooner or later than that at a parent or professionals' request. Progress on goals is tracked by the team and adjustments to the plan are made if needed. The SOC case is closed when the family identifies that they are no longer in need of service coordination, supportive services or when the child is placed out of the home or placed in Children Services custody. Those cases are then followed and monitored by the placing agency as Summit County FCFC has only one SOC coordinator and is unable to monitor closed SOC cases. However, when the child is ready for discharge or returns to the parent's custody any agency worker or parent may again contact the SOC service coordinator to re-open the case and assist with coordination of services to help support and maintain the child in their home and community.

Children involved with the Juvenile Court system who are alleged unruly are typically diverted out of the system by the court referring the child to one of the county's youth diversion programs of which there are several. The court also has a Family Resource Center which is a grant funded program that will work with families to link them to community resources so the youth does not further penetrate the justice system. Children who are alleged or adjudicated unruly may also be offered a mentor, respite, or an alternative school placement. These are just some of the programs the court has to divert unruly youth from the system. They also may refer them to FCFC for service coordination and funding assistance for some of the above mentioned services.

SUMMIT COUNTY CLUSTER FOR YOUTH

The Summit County Cluster for Youth (Cluster) is the cornerstone for the assessment and decision making on multi-need, multi-agency involved youth. These are typically the "deep end" youth. The four placing agencies, in Summit County, (ADAMHS Board, Juvenile Court, Children Services and DD) approve Cluster cases and the use of funding from the Shared Pool. This collaborative has been in place since the 1980's and works well for Summit County and all agency personnel are aware and trained about the Cluster referral procedure. A youth, birth through 21 years of age, who exhibits more than one emotional, physical, or developmental difficulty and thus require the services of more than one system, may be referred, to the Cluster by an agency, anyone in the community or a parent. A referral is made to Cluster, by an agency, when service providers are unable to adequately meet the needs of the child and/or the family either programmatically or financially or if coordination of services is a problem. The Cluster operates with three councils: Executive, Administrative, and Review Council.

EXECUTIVE COUNCIL (Juvenile Court Judge, Children Services Director, DD Director, ADAMHS Board Director and Child Guidance & Family Solutions President)

- Meets quarterly
- Reviews annual Cluster data
- Reviews Shared Pool expenditures
- If indicated and/or needed would review and make decisions on case responsibilities and/or funding
- Assures resolution of case disputes through the Dispute Resolution Process
- May direct Cluster to strategize and develop recommendations to resolve a case and/or system issue
- May make recommendation on projects on which the Cluster should embark

ADMINISTRATIVE COUNCIL (Appointed representatives from Children Services, Juvenile Court, DD, ADAMHS Board and Child Guidance & Family Solutions)

- Meets monthly
- Reviews and approves cases being requested for presentation to Review Council by the Cluster coordinators or one of the other administrators
- Discusses and approves funding for placement and/or services through Shared Pool and CCBH funds
- Oversees the Shared Pool
- Monitors service delivery
- Recommends services to transition active Cluster youth from out of home placement to the community and/or to the adult system

REVIEW COUNCIL (*see membership list*)

- Meets monthly
- Reviews new and ongoing Cluster cases
- Reviews year end reports and data
- Reviews trends in cases in order to facilitate planning efforts and program development
- Reviews the Service Coordination Plan annually
- Identifies and addresses gaps in service

Financially, the Cluster may access:

- CCBH 404 dollars (The ADM Board has allocated all dollars to Cluster)
- Shared Pool (Contributors: Children Services, DD, Juvenile Court & ADAMH board)
- Local agency dollars of the four placing agencies: Children Services, DD, Juvenile Court & ADAMH board. The agency representatives have the knowledge and authority to allocate their agency's placement dollars to meet the needs of these children.

Programmatically, the Cluster strives to:

- Identify and resolve system barriers
- Identify gaps in service
- Develop programs and projects to enhance services

Coordination of Services, the Cluster:

- Develops joint service coordination plans with professionals and the parent
- Delineates services, responsibility and cost
- Designates a Lead Case Manager
- Monitors delivery of services
- Assists with discharge planning

CLUSTER COORDINATORS

Summit County has two coordinators, one of which is also the supervisor, who work for the Cluster and whose salaries are paid by the Summit County Juvenile Court, Children Services, DD and the ADAMHS Board through shared pool funding. They are supervised by the Director of FCFC and are employees of and housed at FCFC's Administrative Agency, the Summit County Health Department. The coordinators have experience and knowledge about systems, services and programs in the community. They are a valuable resource at both the case and system level.

REFERRAL PROCESS

Each of the four child and family serving agencies in Summit County, who have the ability to place children outside their homes for needed services and/or treatment, has an appointed representative to the Cluster Administrative and the Review Council. There are also twelve agencies that sit on the Cluster Review Council who have appointed representatives. (*see Cluster membership list*) A referral should first be discussed with this representative to assure that the agency representative is adequately informed about the case and that all approved documentation is attached. There is a referral form (*see addendum A*) and a Cluster release of information (*see addendum B*) that is completed and sent via email, fax or regular mail to one of the Cluster Coordinators. The Judge and magistrates also refer cases to Cluster via the Journal Entry. It is known by all agencies making a referral to Cluster that a parent, and the youth if able to participate, is expected to be invited to all staffings. The Cluster believes that families should not have to give up custody to obtain services for their children. Data for 2007-2009 documented that 76% - 84% of youth referred to Cluster were in their parent's custody. The remaining percentage was in Children Services custody due to abuse and/or neglect. (*see Cluster Data report 2009*). If a parent is not involved with one of the Cluster agencies or if a private agency is making a referral, they should contact one of the two Cluster Coordinators. A private agency must complete the referral form and release of information and submit it as any of the Cluster agencies would. The parent may contact one of the Coordinators by telephone to initiate a staffing. The parent may also contact the Coordinator if they are receiving services with a community agency but do not feel that their needs are being met. Parents do not have to complete a referral form but do sign a Cluster release of information authorizing shared communication with Cluster member agencies and other team members. The Coordinators are paid through the Shared Pool and are FCFC staff. Their responsibility is to facilitate a family team planning meeting (staffing) in order to develop a collaborative family driven service coordination plan. It is stated at all staffings that all information shared by team members is strictly confidential and a confidentiality agreement is signed by all team members (*see addendum C*).

Once the Cluster coordinator receives the release of information and referral packet, identified team members, which includes agency personnel, the child's school district of origin/attendance, the family and whoever the parent wants to bring as a support person, are invited to a staffing. The date the referral was received is documented on the last page of the referral form. Invitations to staffings are done via email or by telephone. The referent is responsible for inviting the family as they are the person who knows the child and family best. The parent may invite and bring any informal support person. If they do not have anyone they are informed there is a parent advocate available through Mental Health America PEERS and are given the telephone number. A staffing is usually scheduled within one to two weeks and is held at a date, time and place that is typically, convenient for the family. This may not always be possible in circumstances where the court orders an emergency staffing due to the child being in the detention center or if the child is in the hospital. Also, if Children Services has custody or the child is already in an out of home placement the staffing will be held wherever is most convenient for the majority of team members. Staffings are scheduled prior to any out of home placement, unless otherwise ordered by the Juvenile Court, and are done within 10 days after a placement if the case is referred to Cluster. The placing agencies have their own protocol for placement of children that are not Cluster involved cases.

The goal of the staffing is to look holistically at what the family wants and needs. To assist in gathering and discussing pertinent information the Cluster has identified nine primary life domains on the referral packet. These domains are: Family, Residence, Education/Vocational, Emotional/Psychological, Social/Recreational, Medical, Safety, Legal, and Religion. This is to encourage and remind case managers to look holistically at the family and to consider not only the identified child but the needs of the parent(s) and siblings. By including the parent/guardian and child in the gathering of information and in decision making about services, it assists in assuring that services are culturally sensitive and responsive to their strengths and identified needs. The staffing should be family and child driven, strength based, culturally sensitive, holistic, creative and collaborative. Summit County strives to be culturally sensitive. It is believed that since the family is involved at each step in the process the information gathered from the parent/guardian affords an opportunity to be culturally sensitive. If there are cases where cultural sensitivity is explicitly needed, we are fortunate to have the International Institute which has social workers with expertise in languages and cultures that we can contact for guidance and/or if a translator is needed. The staffing should not be a discussion of blame for a provider, child, or parent nor should it be agency/system driven or pathology focused.

PARTICIPANTS

Participants will include those individuals or agencies that are currently involved with the family and approved by the family unless there are mandated agencies due to custody or legal issues such as Juvenile Court or Children Services. This may also include professionals, not presently involved, who may be potential service providers. The family may invite either informal or formal support people that they identify as support for them. A parent advocate, through Mental Health America PEERS, may also be offered to the parent if the parent wishes.

STRUCTURE OF THE STAFFING/DEVELOPMENT OF SERVICE COORDINATION PLAN

The Cluster Coordinator facilitates the staffing. Introductions of all attendees take place. Then the coordinator explains the role of Cluster and the process of the staffing. There is a statement of confidentiality and an agreement is signed (*see addendum C*) by all in attendance that no information discussed in the staffing will be discussed out of the staffing. Each agency representative is then asked to review their agency's involvement with the family (past and current history, services provided, testing results etc). The family's strengths needs are discussed as well as barriers to services for identified needs. The family is asked to be a part of the discussion to clarify any incorrect or misinformation given as well as what services they believe worked or didn't work for their family. After all discussion there is development of the individual family service coordination plan. The plan should be built on what the family and child want and need and should be responsive to the strengths, needs, culture, race and ethnicity of the family and provided in the least restrictive environment. If the child is already out of the home the treatment providers are asked to review any recommendations for the family and child. The plan should state specific goals, time frames, and designate the person/agency that is responsible for implementation. If identified services or supports are not available, the plan will state how alternative services were identified. Any gaps in service availability will be reported to the Administrative and Review Council for discussion as to how to address these gaps in services. Team members, including parents and the child, identify which activities they will accomplish. The exception would be if an agency has a legally mandated requirement to provide certain services. A lead case manager is identified. This is done so that the parents, and other agency personnel, have a "point person" to contact for information or clarification on the plan. Each case is unique and staffings are held as needed for that particular case. Typically they are held monthly unless a team member or the court requests it to be held sooner or later. If the child is out of the home in a therapeutic placement team meetings are held monthly. The lead case manager and parent attend these meetings. The Cluster coordinator will attend meetings in out of home placements quarterly and at any transition times such as discharge planning meetings. The case manager will relay information to the Cluster Coordinator after each out of home placement meeting. Any team member may request a staffing be held at any time.

An important part of the service plan is a crisis and safety plan. The Cluster Coordinators do not develop these plans. Cluster member agencies develop the crisis and safety plans with the family since they know the family best. The plan may be discussed at the Cluster staffing and revised as needed. In each placing agency they are now developing crisis and safety plans that are very similar to the FCFC SOC crisis and safety plan.

The Cluster Coordinators present the case and recommendations to the Administrative Council for approval to present to the Review Council to officially open the case with Cluster for continued service coordination or funding assistance. A decision may be made that a case may not become an "official" Cluster case if there was one staffing to link the family to needed services or if an agency, or the family, decides after the staffing that there is not a need for the Cluster to coordinate services and the family will just continue working with a particular agency.

The unruly and/or alleged unruly youth referred to the Cluster follow the same procedures as the above. The Cluster Coordinators are knowledgeable about preventive services in the community

especially those who provide services for or work with unruly youth. One of these resources is our Youth Divisions. The Youth Diversion Programs are housed in a community's police department and have an officer that works with the social workers to deter unruly youth from entering the Juvenile Justice System. Services, in addition to case management, are varied and may include: respite, parent education, mentoring for the youth. If the child and family successfully follow through with the program the charges are dropped. There are also other programs/services that may be used as wraparound services for example, youth mentors, Safe Landing which is a respite shelter facility, Truancy Task Force, mediation, New Beginnings, etc. There are also two specific programs that work with the deep end youth whose goal is to maintain them in the community. These programs are Crossroads (co-occurring substance use and mental health intensive probation) and ICT (Integrated Co-Occurring Treatment) The latter is a unique home based program offered through a local mental health agency that works in conjunction with Juvenile Court. Therapists have dual expertise in both mental health and substance abuse.

FISCAL STRATEGIES

Funding decisions for services or supports identified on the SOC service plan are discussed by team members. Team members first identify the service needed, how long it is needed and the cost of the service. If funding is needed through the FCSS: SOC dollars the SOC coordinator consults with the supervisor and FCFC director to ensure it is an allowable expense. If an involved agency is able to fund a service or support they do so. The Summit County Health Department is the fiscal agent for FCFC and SOC. All invoices are paid by the fiscal agent and expenses are tracked on an excel worksheet that is accessible on a daily basis. FCFC looks at all funding sources (agency funds, Cluster shared pool, FCSS:SOC, CCBH 404, program scholarships, and family contribution) to maximize resources to assist and support families. FCFC has also begun referring youth to HOME Choice to access services and funding to assist families with supportive services. Funds saved by a youth discharging early from a residential setting are reallocated to the shared pool to assist other families who need support or youth who may need placement for a short time out of their home for treatment. Funding, through the Cluster Shared Pool dollars, for all Cluster cases can only be approved by Administrative Cluster. Each agency has given authority for funding decisions to an appointed representative on Administrative Cluster. This policy was made for two reasons: 1) Funding issues often derail creative thinking and 2) the Administrative Cluster has the authority to make these decisions. This council meets monthly to discuss cases and makes funding decisions. The Cluster may access Shared Pool funds, HOME Choice, FCSS: SOC and CCBH 404 funds. The Summit County ADAMHS board has allocated all the CCBH 404 dollars to the Cluster and the Administrative Cluster determines how those dollars will best be spent.

PUBLIC AWARENESS/TARGETED MARKETING

Summit County Cluster has been providing a Cross Systems Training program for professionals since 1995. To date almost 500 community professionals have been trained. The training program is 6 months long. Participants attend one full day per month. Topics include professional collaboration, state and local collaboration, parent and professional partnerships, and wraparound. There are two additional sessions where participants travel to community agencies that provide services to families so they are familiar with the agency and the services

they provide. There are also speakers who present information about IEP, MFE, IDEIA, child welfare, different types of families, mental health, juvenile justice, and developmental disabilities. The two Cluster Coordinators also educate the professionals on the Service Coordination Plan in Summit County. They learn the process, how to access it, make a referral, and mandates of the plan. They are encouraged to inform the families they work with on the ability to self refer for service coordination. The Cluster Supervisor also conducts training at agencies about the availability of service coordination and the referral process to direct care staff as well as agency managers. Families are made familiar with the service coordination plan through local agencies or via the Summit FCFC website. Mental Health America also has support groups for families managing children with behavioral health issues. Several parents who have been involved in service coordination attend these groups and learn about service coordination there. Many families who have contacted Summit FCFC have stated they learned about FCFC service coordination by viewing the website or word of mouth.

EVALUATION

Evaluation is a process of systematically determining and showing evidence of expected and unexpected outcomes and impacts of the intervention effort on children and families, service providers and the community. Evaluation assures that children and families actually receive needed services, documents gaps in service and leads to strategies for improvement. Monitoring is closely tied with evaluation. The Cluster has always collected data to meet these goals at both the case and system level but have not had a systematic data system set up to collect the data and then to develop reports in order to understand our impact and make system recommendations if indicated. The Cluster did develop a database in approximately 2006 to track Cluster youth. A 2009 data report is attached. It is difficult to determine how or if Cluster's service coordination is helping reduce the length of stay of youth referred to the Cluster since most children referred to Cluster is for funding assistance of a placement for which the youth was in prior to being referred to Cluster. Also, several youth are referred to Cluster for coordination and planning for the most appropriate placement. Once the case is officially opened as a Cluster case the Cluster coordinator monitors the case to ensure the team is planning for needed supportive services when the child is discharged from an out of home placement. Summit County gives their assurance that data would be shared with the state for the purpose of evaluation if requested.

The Cluster has also used individual cases scenarios to illustrate how well or how problematic some service coordination plans have been implemented. These illustrations have been shared with the Cluster Executives, Review Council and Cluster Cross System Training as a learning tool.

The Cluster annual report serves as an evaluation tool which is shared with the Review and Executive Council of Cluster and also the General Membership of FCFC. Results of the report is utilized to improve our service coordination mechanism and to improve services to family and children.

DISPUTE RESOLUTION

SUMMIT COUNTY CLUSTER FOR YOUTH

The Cluster's dispute resolution process has seldom been used which is a tribute to the sense of collaboration, trust and consensus building that exists. The existence of a flexible Shared Pool has also been a major contributor to the lack of dispute among agency providers. Summit FCFC FCSS:SOC will follow the same dispute process, and timelines, as the Cluster with the exception that all disputes will be put in writing to the SOC coordinator who will in turn provide them to the Summit FCFC director. If the case can not be resolved by a written decision of the FCFC director it will then be presented to the FCFC executive committee to render a decision.

Philosophically the belief is that problem solving through consensus building is the most successful and beneficial approach to dispute resolution. Due to this belief, team building and problem solving are components of the Cross-System Training Program. The Cluster and Family & Children First Council will encourage and support this principle through all steps of the dispute resolution process. The Cluster and FCFC will adhere to all applicable laws/regulations in regards to confidentiality and will comply with all applicable HIPPA regulations concerning the use and disclosure of protected health information.

Summit County also recognizes that community agencies may have in place a formalized dispute resolution process for their employees and their consumers. Parents will continue to use local agency grievance procedures to address disputes not involving service coordination. This process is in addition to and does not replace other rights or procedures that parents or custodians may have under other sections of the Ohio Revised Code. Many agencies, including Children Services, Child Guidance & Family Solutions, DD and Mental Health America, also have ombudsmen to listen to parents concerns in regards to service/treatment. The utilization of these existing structures will be encouraged and supported as first steps. The parent and agency providers are informed of the Dispute Process at the conclusion of the initial Service Coordination Planning Meeting. Parents are included in all aspects of the dispute process, if they choose. This process does not override any decision made by the juvenile court judge regarding out of home placement, long-term placement, or emergency out-of-home placement.

If a parent or guardian wishes to initiate the dispute resolution process they need only put their concern in writing to the Cluster supervisor. This is true for whether a parent/guardian expresses concerns regarding FCFC service coordination or concerns about their individual service plan.

Cluster will resolve non-emergency disputes no later than 60 days after the parent or custodian initiates the dispute process. FCFC will make findings regarding the dispute and issue a written determination of its findings. All services and funding provided will continue to be provided during the dispute process. The parties may, by mutual agreement, waive the time limits. Any waiver so agreed upon shall be in writing and signed by the FCFC Director and all parties pertaining to the dispute. All decisions throughout the dispute process must be in writing.

Emergency situations would have to demonstrate why a time line of 60 days is detrimental to the child, family or agency since services would continue during the dispute process. It is hard to define an emergency situation but in general it would have to demonstrate why the continuation

of present services or lack of appropriate services is placing the child in danger either physically and/or emotionally. In these situations the time line would be reduced to two weeks or less.

The following dispute resolution process between child/family to agency and child/family to their service coordination plan and agency to agency will apply specifically to Cluster. Non-emergency cases will be resolved within sixty (60) days or less.

1. If there is a significant and unresolved conflict regarding any aspect of the Service Coordination Plan which may include, but is not limited to, identified services; funding of those services; or the lead case manager role by either the parent or any agency member of the team, and/or a dispute between agencies every attempt should be made to resolve the conflict within the parent/professional service coordination team.
2. If the parent/professional team cannot resolve the conflict, a member of the agency team or a family member may file a formal statement of dispute. The statement and any supporting evidence should be sent to the Cluster Supervisor who will present the request for dispute resolution to the Administrative Council. The date the complaint is received becomes the official date and begins the time line for dispute resolution. The Administrative Council will review all relevant information and render a written decision within one week.
3. If the Administrative Council cannot resolve the conflict and/or the person/agency making the complaint is not satisfied with the decision the complaint will be referred to the Review Council. The Review Council will review all relevant information and render a decision within two weeks of the referral from the Administrative Council.
4. If the Review Council cannot resolve the conflict and/or the person or agency making the complaint is not satisfied the complaint it will be referred to the Executive Council. The Executive Council will review all relevant information, may ask for additional information and/or testimony, and will render a decision within two weeks. The Executive decision will be put in writing along with supporting documentation if applicable. The entire process will be resolved within sixty days.
5. If resolution cannot be resolved through this Dispute Process the final arbitrator would be the Juvenile Court Judge. The request for a court hearing must be filed, by the disputing party to the Judge, within 7 days after the failed dispute resolution. The Cluster Coordinator(s) will assist in preparing all pertinent information for the court. The court shall hold the hearing as soon as possible, but not later than ninety (90) days after the motion or complaint is filed. The court may conduct the hearing as part of the adjudicatory or dispositional hearing concerning the child, if appropriate, and shall provide notices as required for these hearings. In cases in which the hearing is not part of the adjudicatory or dispositional hearing the hearing shall be limited to a determination of which agencies are to provide services or funding for services of a child. The court shall issue an order directing one or more agencies represented on the council to provide services or funding for services to the child. The order includes a plan of care governing

the manner in which the services or funding are to be provided. The court shall base the plan of care on the family service coordination plan. An agency required by the order to provide services or funding shall be a party to any juvenile court proceeding concerning the child. The court may require an agency to provide services or funding for a child only if the child's condition or needs qualify the child for services under the laws governing the agency. The decision of the court is final and binding.

6. The Cluster Supervisor will be responsible for conveying the written decision at any step in the dispute resolution process to all pertinent bodies, which will include but is not limited to, the family, agency team members, Cluster Review Council, Administrative Council, Executive Council and Family & Children First Council.
7. All filed disputes will be tracked and reviewed at the yearly Cluster Retreat when the service coordination plan is reviewed.
8. The Cluster may consult with the Ohio Family & Children First Council if it is a unique case where there are specific issues with funding, locating an appropriate service and/or if administrative rules prohibit a solution.

If there is a formal request of OFCF to review a complaint, Summit county will utilize the OFCFC Service Coordination Dispute Referral form and the Service Coordination Administrative Review Referral form.

This Dispute Resolution Process is for all applicable Cluster complaints. Ineligible complaints may involve eligibility for programs/services which should be directed to the Due Process procedures of the agency(s) involved. Also disputes involving an Individual Educational Plan (IEP) covered under O.R.C. Chapter 3323 and Individuals with Disabilities Educational Improvement Act (IDEIA) are to be channeled through the appropriate Local Educational Authority (LEA). If the family or agency representative disagrees at an initial service coordination meeting prior to signing the service coordination plan and becoming a cluster case there is no requirement to comply with this dispute process. Once a plan has been instituted this dispute process becomes effective. Services and/or funding during the dispute resolution process would continue. If an agency that provides services or funds during the local dispute resolution process or court proceedings is determined through the process or proceedings not to be responsible for providing them, it shall be reimbursed for the costs of providing the services or funding by the agencies determined to be responsible for providing them.

In cases that involve Shared Funding a contract is signed by the funding agencies and approved for a specific period of time and an amount with the opportunity to request additional funding if the need exists. Therefore, a request for continuation of funding has to be made 30-45 days prior to termination of the agreement. If the funding agreement terminates without an official request to continue funding there is no obligation to extend funding beyond the original approval dates nor is this subject to the dispute process. This would not affect other services such as case management, etc.

SUMMIT COUNTY HELP ME GROW

1. For Part C – eligible children, Service Coordinators (a) coordinate evaluations and all assessments; (b) facilitate and participate in the development, review, and evaluation of IFSPs; (c) identify available service providers; (d) coordinate, facilitate and monitor the timely receipt of services; (e) inform families of the availability of advocacy services; (f) coordinate with medical and health providers; and (g) facilitate transition plans to preschool and/or other services if appropriate. Service Coordination policies are determined by the Ohio Department of Health Bureau of Early Intervention Services and are mandated to follow federal law as written in IDEA.

2.
 - (1) Help Me Grow referrals can be made by calling, faxing or mailing the referral form to the Summit County Intake & Referral Central Site. Once the referral has been received, the Intake Coordinator records the referral in Early Track, which is the state web database for Help Me Grow. The referral is then faxed to one of the three community agencies that are sub-contracted to do Service Coordination. A letter is sent to the family within 48 hours informing them of the agency that will provide Service Coordination to their family. A Service Coordinator is assigned, and contacts the family through a home visit to begin enrollment.
 - (2) Notification by letter or e-mail will be made at least 2 weeks in advance to the family and person or persons directly involved in services to the family, along with anyone the family wishes to be present at the meeting.
 - (3) An IFSP meeting will be completed within 45 days of referral and reviews done at least every 180 days. If they wish to review the plan sooner, they can tell their Service Coordinator and she will schedule the meeting.
 - (4) The outcomes and progress being made is monitored at each IFSP review. IFSPs are also reviewed independently by each Service Coordinator's Clinical Supervisor to ensure quality and that timelines are being met.
 - (5) The Consent and Release of Information states that information will only be shared with agencies listed and initialed by parents on the form.
 - (6) Summit County Help Me Grow uses the Routines Based Interview (RBI) as a tool to assess strengths and needs and cultural structure of the family. In addition, the entire IFSP process assesses the child's strengths and needs as well as the families.
 - (7) Service coordinators facilitate and participate in the development, implementation, review and monitoring of the IFSP and its timelines. Facilitation includes coordinating a meeting time and location that results in the participation of the family and as many service providers and evaluation team members involved with the family as possible. An RBI is completed prior to the IFSP and, consequently, outcomes are identified by the family at that time. Information is gathered by the Service Coordinator for the IFSP from the time the family is enrolled. The IFSP, or Individualized Family Service Plan, is the interaction, collaboration, and partnership between parents and providers resulting in a written plan that:
 - lists outcomes for individual families and their infant or toddler, and
 - describes resources/services and their coordination that will support those outcomes;
 - is made to be flexible;
 - can be developed in many ways;
 - can be changed whenever the family feels it needs to be updated;

- can include all types of services, skills and materials needed to help the child;
- identifies and organizes formal and informal resources to facilitate families' goals for their children and themselves;
- identifies the family's concerns and needs.

(8) Procedural Safeguards are in state and federal policies:

(A) Children and their families eligible for HMG but not eligible for Part C, may file a complaint through the county family and children first council's dispute resolution process as required by section 121.37 of the Revised Code.

(B) The department, as the lead agency shall establish procedural safeguards that are consistent with Part C regulations. The department in partnership with the state and county family and children first councils is responsible for assuring effective implementation of these procedural safeguards by each state or local agency or a private agency in the state that is involved in the provision of Part C services. The department assures implementation through the following activities:

(1) Disseminating written guidance regarding procedural safeguards to:

- (a) County family and children first councils;
- (b) Help me grow project directors;
- (c) Centralized intake and referral sites;
- (d) County boards of mental retardation and developmental disabilities;
- (e) County departments of job and family services; and
- (f) The family support consultant network;

(2) Entering into interagency agreements with the department of mental retardation and developmental disabilities and the department of job and family services, which includes the agreement to work together to consistently implement the Part C procedural safeguards, regulations and other applicable policies; and

(3) Monitoring county compliance with this rule.

(C) The department shall develop and assure the implementation of a process for the resolution of complaints regarding the provision of Part C services. The process shall specify the procedure for:

- (1) Filing a complaint with the county FCFC;
- (2) Filing a complaint with the department;
- (3) Resolving the dispute through mediation or an administrative hearing within thirty days from receipt of the request for mediation or an administrative hearing; and
- (4) Resolving the dispute through investigation by the lead agency within sixty calendar days from receipt of the complaint.

(D) Each county FCFC shall develop and maintain a resolution process for complaints, which shall be consistent with Part C.

(1) The FCFC shall notify the department of the complaint in writing (via electronic or U.S. mail or facsimile) within seven calendar days of receipt of the complaint; and

(2) The FCFC shall issue a written decision to the complainant and the department within thirty calendar days from receipt of the complaint.

(E) Each provider of Part C services may develop and maintain a resolution process for complaints which shall be consistent with Part C. If the provider has a resolution process for complaints:

(1) The provider of Part C services shall notify the department and the FCFC of the complaint in writing (via electronic or U.S. mail or facsimile) within seven calendar days of receipt of the complaint; and

(2) The provider of Part C services shall issue a written decision to the complainant, FCFC and the department within thirty calendar days from receipt of the complaint.

(F) Upon receiving a complaint, the department, FCFC or provider shall:

(1) Assure the individual registering the complaint has a copy of the procedural safeguards; and

(2) Explain the options available for dispute resolution.

(G) If the department receives notice that a complaint regarding Part C services was filed with the county FCFC or a provider, the department shall monitor the resolution process to assure that the complaint is resolved by the county FCFC or provider within thirty calendar days. If the complaint is not resolved within thirty calendar days, the department shall notify the complainant, the county FCFC and the provider, if applicable, that complainant may select one of the following:

(1) To have the department investigate the complaint in accordance with paragraph (C) (4) of this rule. If this option is selected, the department shall assure that the complaint is investigated and resolved within sixty calendar days from the date the county FCFC or provider received the complaint; and

(2) To mediate and/or to go to an administrative hearing in accordance with paragraph (C) (3) of this rule. The department shall assure that if the complainant selects mediation and/or administrative hearing, the hearing is completed within thirty days from receipt of the request for mediation and/or administrative hearing.

(H) Unless the state or other agencies and parents of a child otherwise agree, the child and family must continue to receive appropriate Part C services currently being provided, during the resolution of disputes arising under Part C. If the complaint involves the initiation of one or more services under this part, the child and family must receive those services that are not in dispute.

3.
 - (1) Service Coordination, IFSP, developmental evaluation, screenings, transition and family support is funded by a blend of ARRA Part C funds, Part C dollars, and General Revenue dollars.
 - (2) Resources are maximized by utilizing what resources are available in the county at no or minimum cost to families. Collaborative efforts between the County of Summit Bd. of DD, Family Child Learning Center, have maximized resources for families.
 - (3) There are currently 5 Service Coordinators who are funded by ARRA dollars 100%. Those families served by these Service Coordinators are considered funded by ARRA as well. Our county utilizes the Part C and the General Revenue funds by blending them to reimburse for Service Coordination by sub-contractees.

4. The Service Coordination system for Help Me Grow is monitored in a number of ways. Clinical Supervisors print out reports from Early Track to show timelines of IFSPs, developmental evaluations, assessments, screenings and transition planning conferences.

The Project Director reviews these same reports on a county level to ensure compliance with timelines. An annual record review is completed to review randomly selected individual files as another measure of monitoring. ODH mandates that each county do an annual self-assessment reviewing specific indicators. Summit County Help Me Grow contracts with the University of Akron Institute for Health and Social Policy to evaluate all aspects of the program as well. They report quarterly and do a final yearly report for FCFC.

SUMMIT COUNTY CLUSTER FOR YOUTH

1100 Graham Road Circle
Stow, Ohio 44224
Phone: (330) 926-5604 Fax: (330) 923-1350

CLUSTER REFERRAL FORM

Date: Youth: D.O.B:
Social Security #: Sex: Race:
Religion: Practicing: Yes No
School District of Origin: Grade:
Referring Person: Agency & Phone:

Mother: Custody: Yes or No
Address: Married: Yes or No
Phone: Divorced: Yes or No
Employer:

Father: Custody: Yes or No
Address: Married: Yes or No
Phone: Divorced: Yes or No
Employer:

Legal Custodian: (If different from parents)

Siblings: Age: Residence:

Is youth at risk for placement out of the home? Yes No
Is youth in need of transition/step down services back to the community? Yes No
Is youth/family in need of wraparound services to maintain the child in the home/Community? Yes No

**CURRENT YOUTH INVOLVEMENT
LAST 30 DAYS**
(check all that apply)

<input type="checkbox"/> Juvenile Court <input type="checkbox"/> Detention <input type="checkbox"/> Probation <input type="checkbox"/> DYS Parole <input type="checkbox"/> Special Education/IEP <input type="checkbox"/> Alternative School	<input type="checkbox"/> Children Services <input type="checkbox"/> Referrals <input type="checkbox"/> Voluntary Case Plan <input type="checkbox"/> Custody <input type="checkbox"/> Protective Supervision <input type="checkbox"/> Substance Abuse Treatment <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient	<input type="checkbox"/> Hospital <input type="checkbox"/> Medical <input type="checkbox"/> Mental Health-Psych <input type="checkbox"/> MRDD <input type="checkbox"/> Respite (out of home)
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**KNOWN FAMILY/CHILD
RISK FACTORS**

<input type="checkbox"/> Abuse/Neglect concerns <input type="checkbox"/> Academic difficulties <input type="checkbox"/> Acute family crisis <input type="checkbox"/> Aggressive behavior towards animals <input type="checkbox"/> Aggressive behavior towards others <input type="checkbox"/> Availability of weapons <input type="checkbox"/> Bedwetting <input type="checkbox"/> Depression <input type="checkbox"/> Drug/alcohol abuse <input type="checkbox"/> Eating disorder <input type="checkbox"/> Family conflict (verbal, physical) <input type="checkbox"/> Fire setting/arson <input type="checkbox"/> Hears voices/sees things <input type="checkbox"/> Homicidal threats <input type="checkbox"/> Impulsive behavior	<input type="checkbox"/> Inability to maintain personal safety <input type="checkbox"/> Inappropriate sexual behavior <input type="checkbox"/> Lack of stable residence/homeless <input type="checkbox"/> Limited ability to control anger <input type="checkbox"/> Limited developmental capacity <input type="checkbox"/> Parent w/chronic or acute mental illness/ developmental delays or MR <input type="checkbox"/> Parent w/drug or alcohol problems <input type="checkbox"/> Parent w/severe chronic illness <input type="checkbox"/> Prejudicial thinking /ideation <input type="checkbox"/> Problems w/authority <input type="checkbox"/> Problems w/peers <input type="checkbox"/> Resides in high crime area <input type="checkbox"/> Robbery <input type="checkbox"/> Running away <input type="checkbox"/> School behavior problems	<input type="checkbox"/> Self injurious <input type="checkbox"/> Sex offender <input type="checkbox"/> Sleep disturbance <input type="checkbox"/> Stealing <input type="checkbox"/> Suicide attempt <input type="checkbox"/> Suicide ideation <input type="checkbox"/> Supervision concerns <input type="checkbox"/> Suspended, expelled, or dropped out of school <input type="checkbox"/> Truancy <input type="checkbox"/> Vandalism <input type="checkbox"/> Verbal or written threats to others <input type="checkbox"/> Victim: physical, emotional, sexual abuse <input type="checkbox"/> Withdrawn <input type="checkbox"/> Other <input type="checkbox"/> Other
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REASON REFERRED TO CLUSTER/ACTION REQUESTED: *(Funding/Coordination of Services/Wraparound Services?)*

OPTIONS TRIED: *(Services: What Works/What hasn't Worked)*

CURRENT PROBLEMS/CONCERNS:

STRENGTHS OF CHILD/FAMILY:

LIFE DOMAINS

(1) **FAMILY:** *(Describe family relationships/interaction? Does the family have a support system? Is the family cooperative with service providers?)*

Has the family experienced a parental separation or divorce in the last year?

Yes No

Has a parent lost their job or are they unemployed?

Yes No

Has a parent been incarcerated, hospitalized or moved away in the last year?

Yes No

Has the child experienced the death of any close family member in the last year?

Yes No

Does the youth complete household chores?

Yes No

Does the youth cause trouble for no reason?

Yes No

Does the youth refuse to do things parents ask?

Yes No

RESIDENCE: *(Where is the youth currently living? If in placement outside the home, where and describe adjustment)*

(2) **SOCIAL/RECREATIONAL:** *(Describe the youth's relationship with adults and authority figures. Does the youth get along with peers? Does the youth participate in hobbies or recreational activities?)*

COMMENTS:

(3) **EMOTIONAL/PSYCHOLOGICAL:**

PSYCHOLOGICAL ASSESSMENT: *(Include Dates of Psychological Testing, Diagnosis, who gave Diagnosis, Current Level of Functioning)*

SEE ATTACHED: *(check if you have testing documentation)*

COMMENTS:

PSYCHIATRIC ASSESSMENT: *(Include Diagnosis, Medication History, Current Medication, Level of Functioning, and History of Psychiatric Hospitalizations)*

SEE ATTACHED: *(check if you have testing documentation)*

COMMENTS:

DISCUSS ANY MENTAL HEALTH CONCERNS AND/OR SERVICES WITH THE PARENTS: *(Does parent receive mental health treatment? If so, where? Diagnosis?)*

IS THE *YOUTH* RECEIVING DD SERVICES?

Yes No

IS EITHER *PARENT* RECEIVING DD SERVICES?

Yes No

SEE ATTACHED: (check if you have any documentation)

COMMENTS:

(4) CURRENT EDUCATIONAL PLACEMENT PROGRAM: (terminology: new/old)

ED MD CD SLD OHI REGULAR OTHER
SBH MH DH LD

SCHOOL CHILD ATTENDS CURRENTLY:

PAST SCHOOLS ATTENDED:

BEHAVIORAL/SAFETY CONCERNS:

BRIEFLY DESCRIBE, (if applicable), PRE-INDEPENDENT LIVING SERVICES THAT ARE BEING PROVIDED OR NEEDED:

(5) SAFETY: (Briefly Describe if There Are Concerns of Safety Either Due to Youths Emotional or Medical Conditions)

(6) LEGAL: (List CSB referral concerns and custody with dates. List Delinquency/Unruly charges with dates and disposition)

Was the child: Adopted Physically Abused Sexually Abused Neglected
Was the child: Adjudicated Delinquent? Yes No Current Previous Pending
Was the child: Adjudicated Unruly? Yes No Current Previous Pending

COMMENTS:

(7) MEDICAL: (Describe Any Medical Problems, Diagnosis, Current Medications, Prognosis for child and parents)

SUBSTANCE ABUSE: PARENT CHILD

DESCRIBE PROBLEM/CONCERN & TREATMENT:

(8) SPIRITUAL: (Briefly discuss if child/family is practicing a religion, support people etc.)

WHO SHOULD ATTEND THE PRE-CLUSTER STAFFING

CHECK (X) WHICH SYSTEMS ARE INVOLVED WITH THE CHILD/FAMILY (currently)

	AGENCY	WORKER NAME SUPERVISOR NAME	PHONE NUMBER
	SUMMIT COUNTY CHILDREN SERVICES		
	JUVENILE COURT		
	DD		
	MENTAL HEALTH <input type="checkbox"/> CHILD GUIDANCE & FAMILY SOLUTIONS <input type="checkbox"/> OTHER _____		
	SCHOOL		
	DEPARTMENT OF YOUTH SERVICES (DYS)		
	HEALTH DEPARTMENT (medical) SUBSTANCE (where) _____		
	GUARDIAN AD LITEM		
	PARENT ADVOCATE		
	PARENTS		
	CHILD (if old enough to participate)		
	FAMILY SUPPORTS (relationship)		

FOR CLUSTER USE ONLY	
CLUSTER COORD. <input type="checkbox"/> MARGE GAFFNEY <input type="checkbox"/> STACEY GARSKE	
DATE REFERRAL RECEIVED: _____	

SUMMIT COUNTY CLUSTER
CONSENT TO EXCHANGE CONFIDENTIAL INFORMATION

Addendum B

CLIENT'S NAME: _____ **DATE OF BIRTH:** _____

I, _____ (relationship to client) _____, authorize:

SUMMIT COUNTY CLUSTER MEMBER AGENCIES

Akron Public Schools	County of Summit Developmental Disabilities Board
Child Guidance & Family Solutions **	Summit County Alcohol, Drug Addiction and Mental Health Services Board *
Children's Hospital Medical Center of Akron	Regional Office of the Ohio Department of Youth Services
Summit County Children Services	Summit County Educational Services Center
Summit County Health Department	Summit County Juvenile Court
The ARC of Summit and Portage Counties	Mental Health America of Summit County

OTHER AGENCIES/PERSONS:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

TO DO THE FOLLOWING:

- Share identifying information across child-serving agencies and systems for the benefit of service coordination and service delivery for the child and family. Identifying information: name, birth date, sex, address, telephone numbers, social security number.
- Share General Medical: Medical records (except for HIV, AIDS) disability, type of services being received and name of agency providing services.
- Share Social History: Treatment/service history, psychological evaluations and other personal information regarding the individual named above.
- Share School Information: grades, attendance records, IEP (individual education plan), MFE (multi factored evaluation), IFSP (individualized family service plan), COEDI (children's Ohio eligibility determination instrument), OEDI (Ohio eligibility determination instrument – adult), transition plans and vocational assessments regarding the individual named above.
- Share Financial Information: public assistance or other financial eligibility and payment information.
- Measure Outcomes.
- **Share Alcohol/Drug Abuse Services:** you may limit the release to the following as desired: Check information that you wish to release: **Client (child) AND parent/guardian must initial each one.**

_____ Diagnostic Information

_____ Evaluation/Assessments

_____ Treatment Plan

_____ Ongoing Communication to Facilitate Services

_____ Psychosocial History

_____ Outcome of Treatment

_____ Recommendations

NOTICE

PROHIBITION ON REDISCLOSURE OR INFORMATION CONCERNING CLIENTS IN ALCOHOL OR DRUG ABUSE TREATMENT

*This information has been disclosed to you from records protected by federal confidentiality rules. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Drug abuse patient records are also protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. parts 160 and 164. (These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.) The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**I understand and acknowledge that this Authorization extends to all or any part of the records designated above, which may include treatment for mental illness (ORC5122.31), alcohol/drug use and/or abuse, (42 CFR Part 2), and/or Human Immunodeficiency Virus (HIV/Acquired Immune Deficiency Syndrome AIDS) test results or diagnoses (ORC3701 24.3).

I understand that knowledge so obtained will be treated in a confidential manner. A photostatic copy of this authorization shall be considered valid. **This consent (unless expressly revoked earlier) expires when the case is terminated from Cluster.**

This form has been fully explained to me and I certify that I understand its contents.

Signature: _____ Date: _____
(Parent/Guardian or Person Authorized to Consent)

Witness: _____ Date: _____

If choosing to REVOKE, complete the following section:	
Written Revocation: I wish to cancel this Release effective: (give date)	_____
	Date
_____	_____
Parent/Guardian or Person Authorized to revoke consent	Date
_____	_____
Witness	Date

CLUSTER REVIEW COUNCIL

2010

2nd Monday of each month

10:30 am – 12:00 pm

Summit County Children Services
264 S. Arlington St.
Akron, OH 44306

***Marge Gaffney**
Summit County Cluster
1100 Graham Rd. Circle
Stow, OH 44224
Phone: 330-926-5731
Fax: 330-923-1350
mgaffney@schd.org

Stacey Garske
Summit County Cluster
1100 Graham Road Circle
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Fax: 330-923-1350
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***Maureen Flynn**
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County of Summit DD Board
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Fax: 330-923-7573
mgrim@mhasc.net

Leigh Belvedere
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Phone: 330-836-5863
Fax: 330-836-6043
Leigh.Belvedere@thearcneo.org

CLUSTER REVIEW COUNCIL

2010

2nd Monday of each month

10:30 am – 12:00 pm

Summit County Children Services
264 S. Arlington St.
Akron, OH 44306

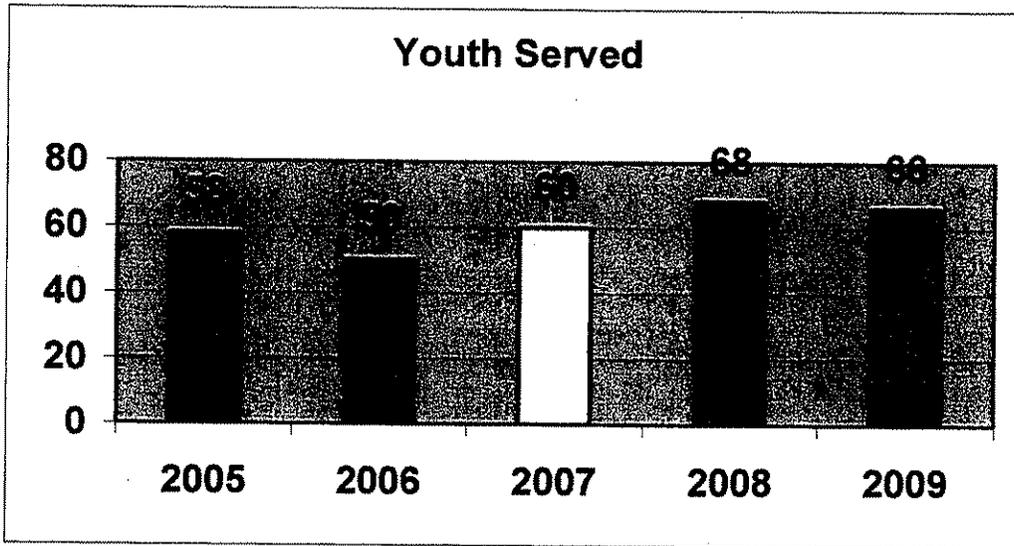
<p>Lisa Johnson Akron Public Schools 65 Steiner Ave. Akron, OH 44301 Phone: 330-761-3016 Fax: 330-761-3058 Ljohnso4@akron.k12.oh.us</p>	<p>Judy McIntyre Summit County Health Department 1100 Graham Road Circle Stow, OH 44224 Phone: 330-926-5761 Fax: 330-923-6370 jmcintyre@schd.org</p>	<p>*Cindy Childress Child Guidance & Family Solutions 405 Tallmadge Rd. Cuyahoga Falls, OH 44221 Phone: 330-945-5999 Fax: 330-945-5699 chilc@cgfs.org</p>
<p>*Terry Walton Summit County Juvenile Court 650 Dan St. Akron, OH 44310 Phone: 330-643-2276 Fax: 330-643-4564 TWalton@cpcourt.summitoh.net</p>	<p>Carol Bowes Akron Health Department 177 S. Broadway Akron, OH 44308 Phone: 330-375-2984 ext.3212 Fax: 330- Bowesca@ci.akron.oh.us</p>	<p>Kay Sonoda Summit County Educational Service Center 420 Washington Ave. Cuyahoga Falls, OH 44221 Phone: 330-945-5600 ext. 511236 Fax: 330-945-6222 kays@cybersummit.org</p>
<p>Revised 6/18/2010 10:41 AM</p>	<p>* Denotes Administrative Cluster Member</p>	

**SUMMIT COUNTY CLUSTER FOR YOUTH
DATA REPORT FOR CALENDAR YEAR 2009**

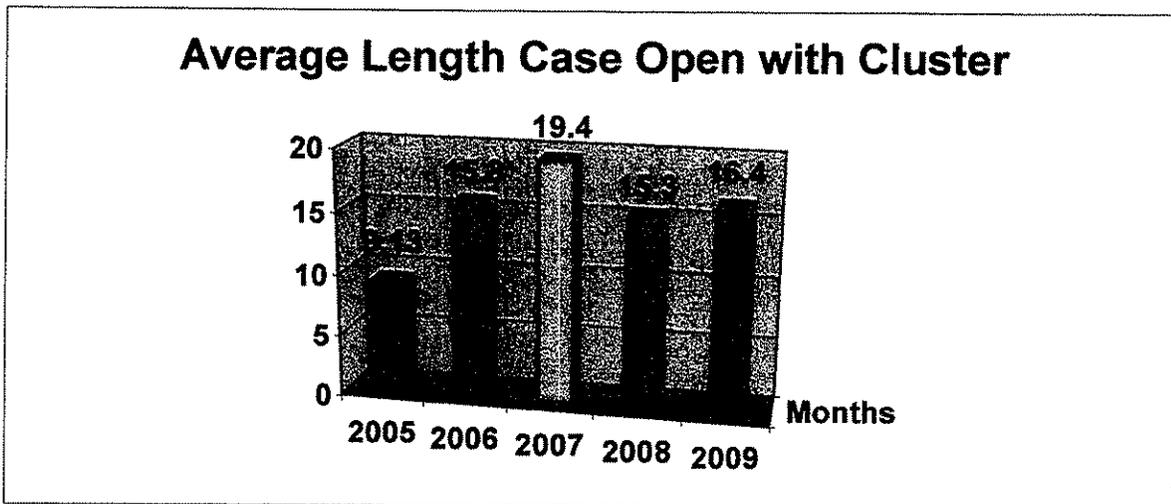
1. Summary Points

- 66 Youth served in 2009
- 38 or 57% had been served in prior year(s)
- 26 cases were closed
- The average length of time a case was open, including all cases opened previous to 2009, was 16.4 months.

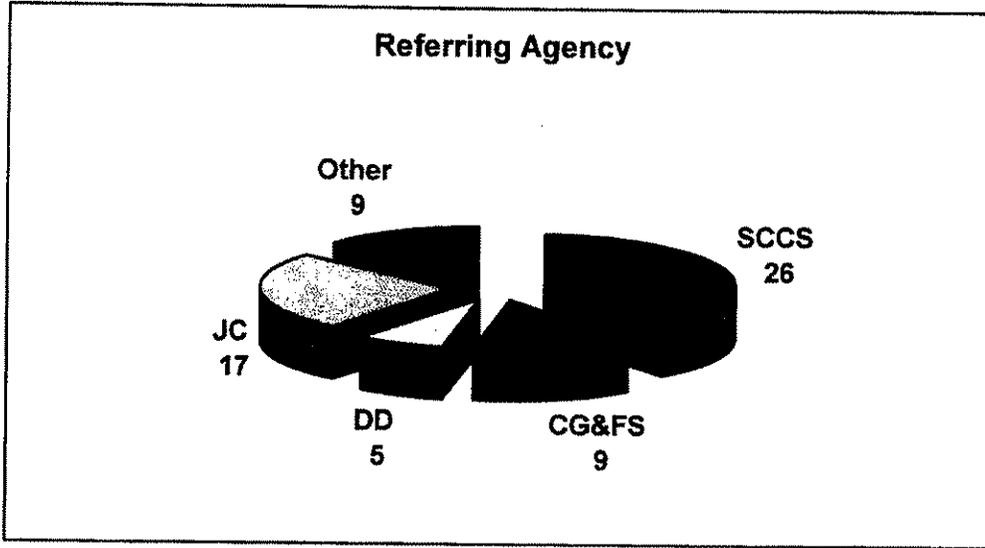
2. Youth Served



3. Average Length Case Open with Cluster



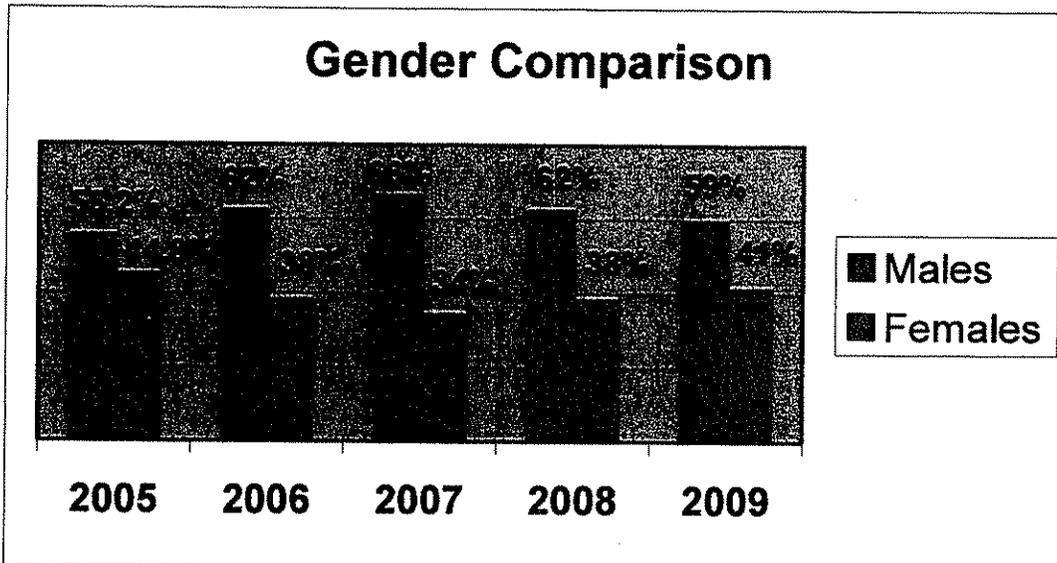
4. Referring Agency



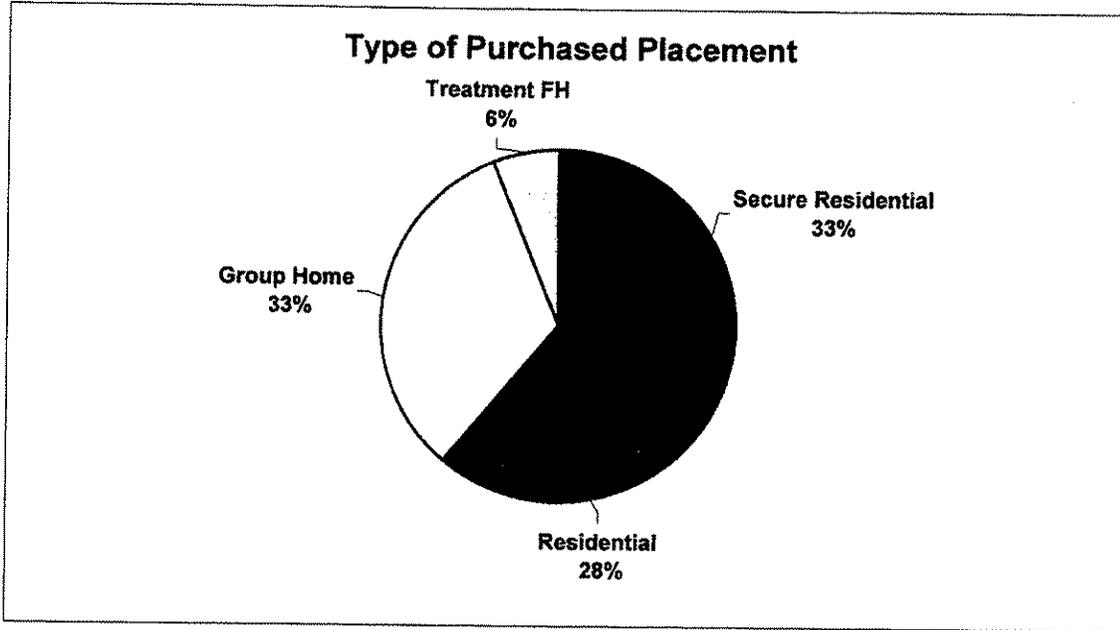
5. Gender / Age Served

- 59% males (39 youth)
- 41% females (27 youth)
- Age range of youth served was 8.4 years to 17.9 years
- Average age served was 14.5 years

Gender Comparison

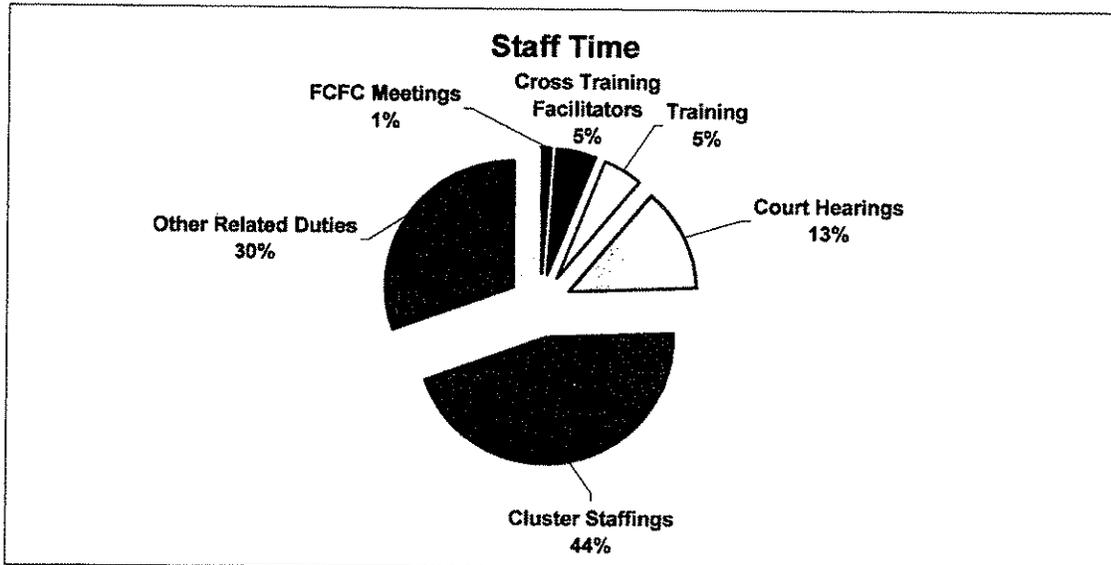


6. Type of Purchased Placements



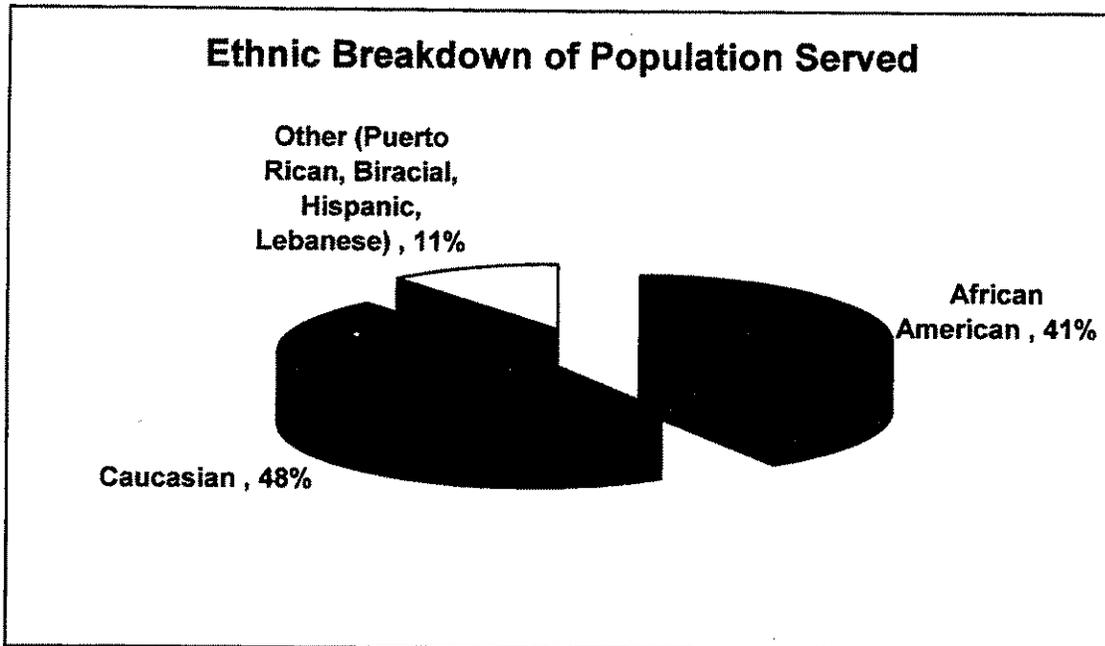
- Range of costs for placements \$76 to \$391 per day.
- Cluster assisted with funding for 18 youth in 2009.
- Three youth received respite services after returning to the community from out of home placement.
- Youth may have been in more than one kind of out of home placement.
- Cluster also funded 3 youth (camp), 1 youth (intensive community support), 4 youth (mentors) and 1 youth (transportation).

7. Cluster Coordinator's Time



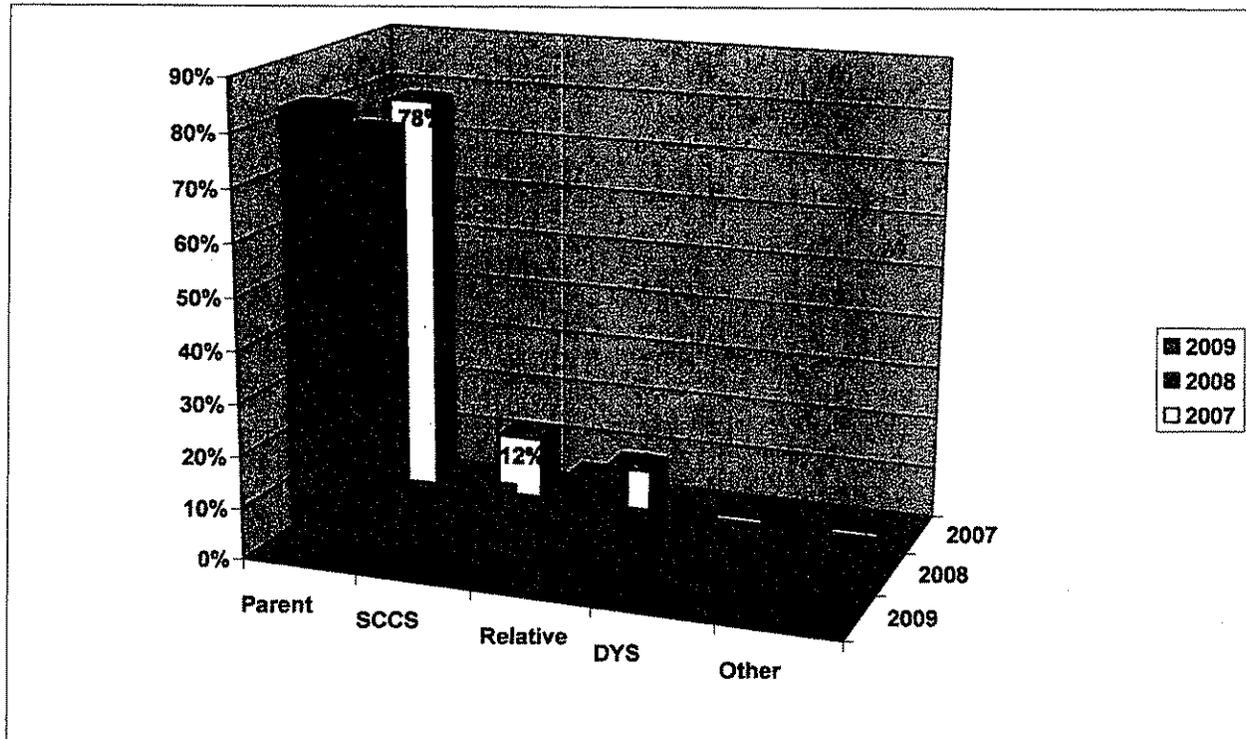
- 267 Cluster Staffings
- 76 Court Hearings
- 62 Parents attended the initial Cluster staffing
- 8 Youth attended the initial Cluster staffing

8. Ethnic Distribution



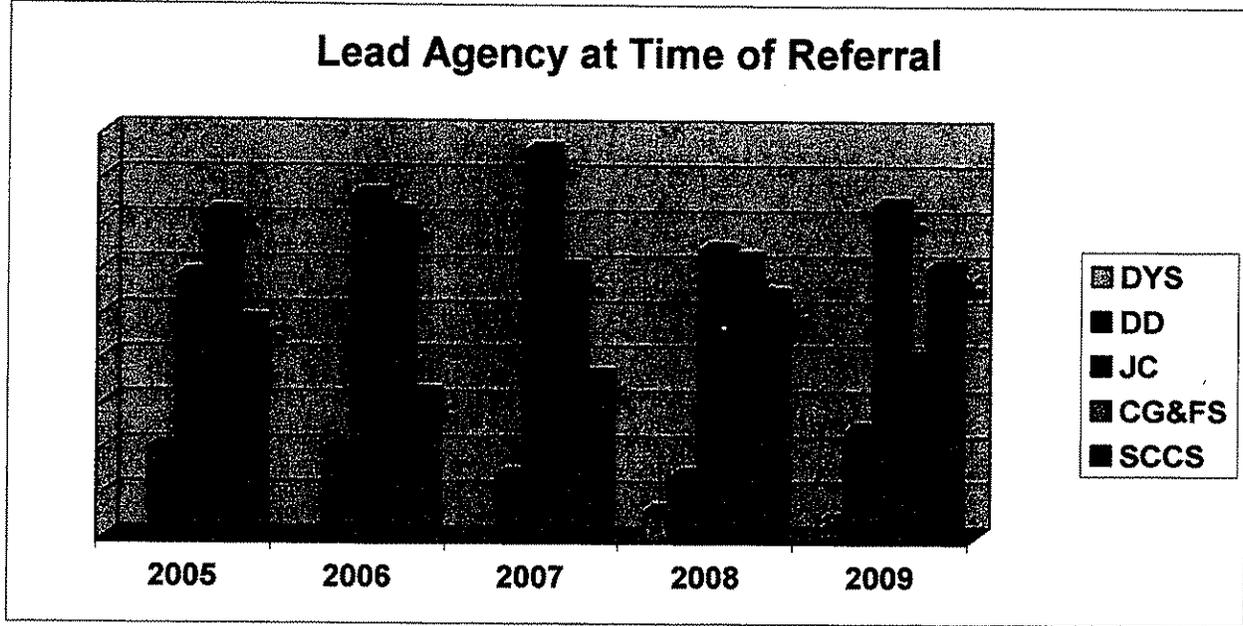
- Caucasian youth comprise a majority of the youth population (77%) ages 10-19 in Summit County according to the 2005-2007 averaged 3 year estimates.
- Minority youth comprise 22.6% of the youth population ages 10-19 in Summit County according to the 2005-2007 averaged 3 year estimates.

9. Person/Agency Holding Custody at Time of Referral

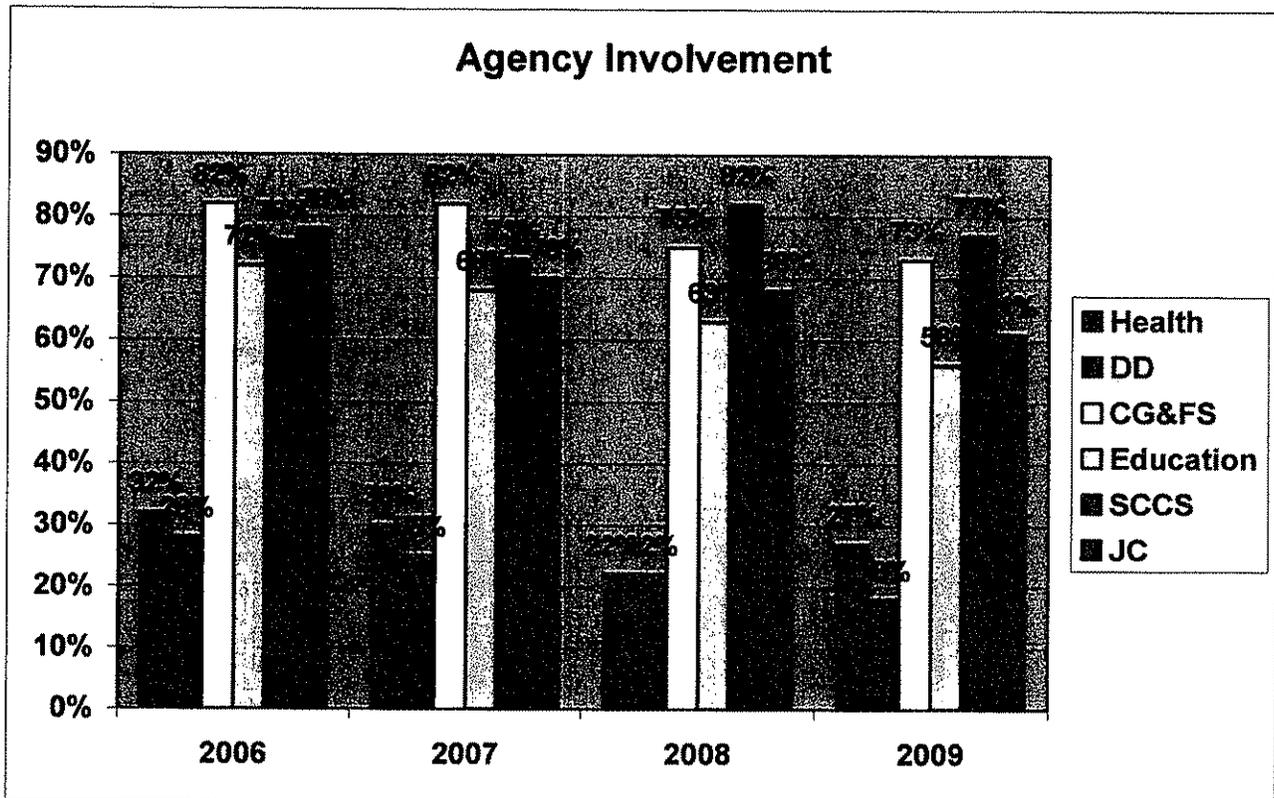


- Over the last 3 years parents have maintained custody in the majority of cases (76% - 84%).

10. Lead Case Manager at Time of Referral

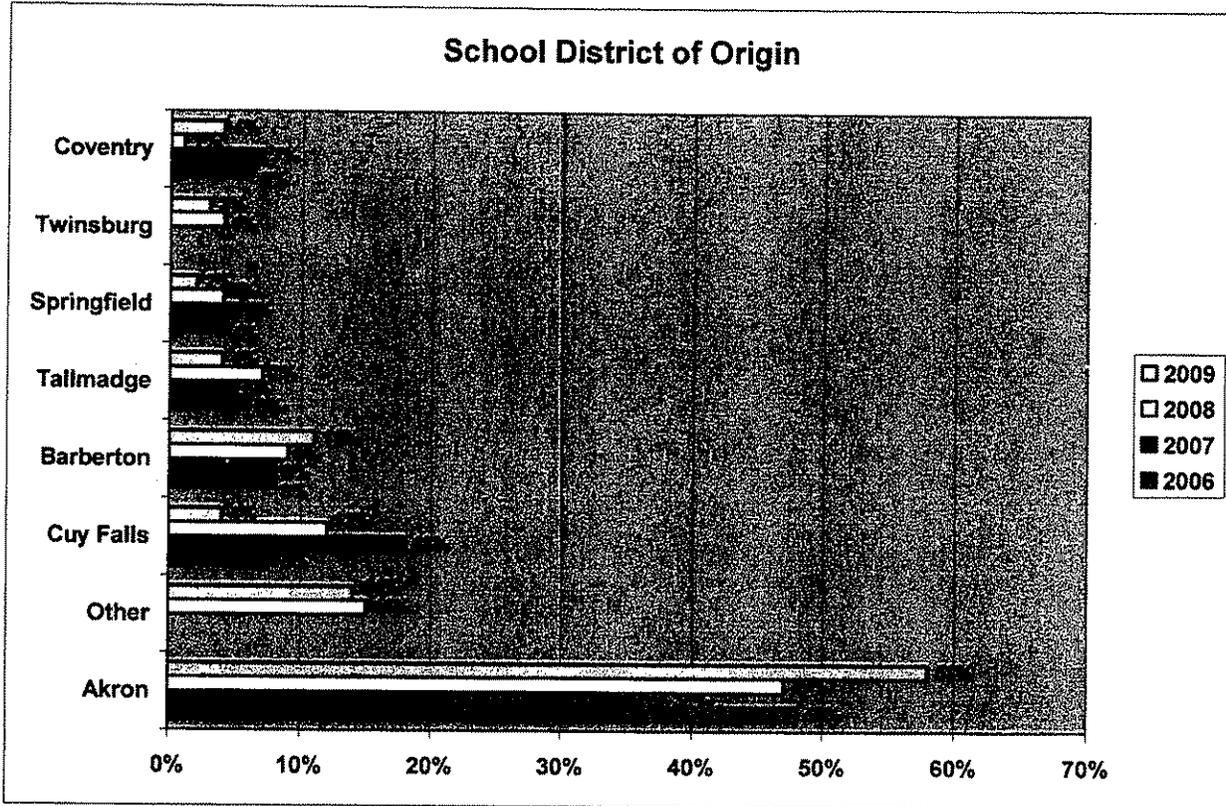


11. Systems Involved



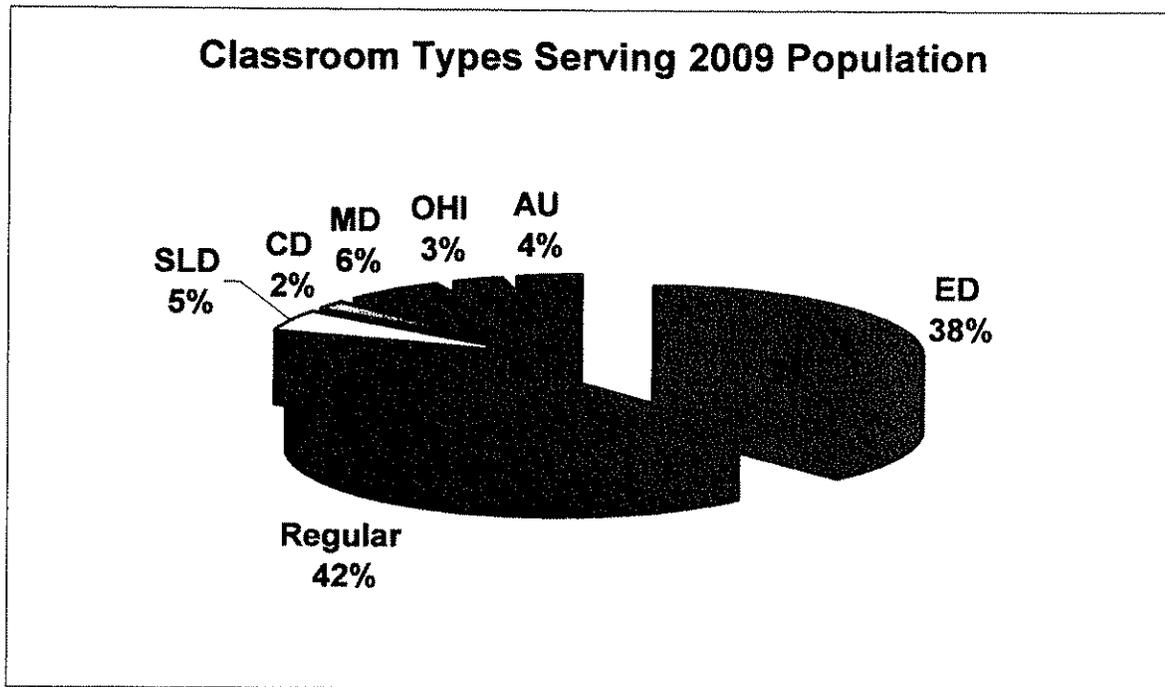
- Majority of youth referred to Cluster, at a minimum, are involved in 3 systems.
- School is counted if a child has an IEP (Individual Education Plan).

12. School District of Origin

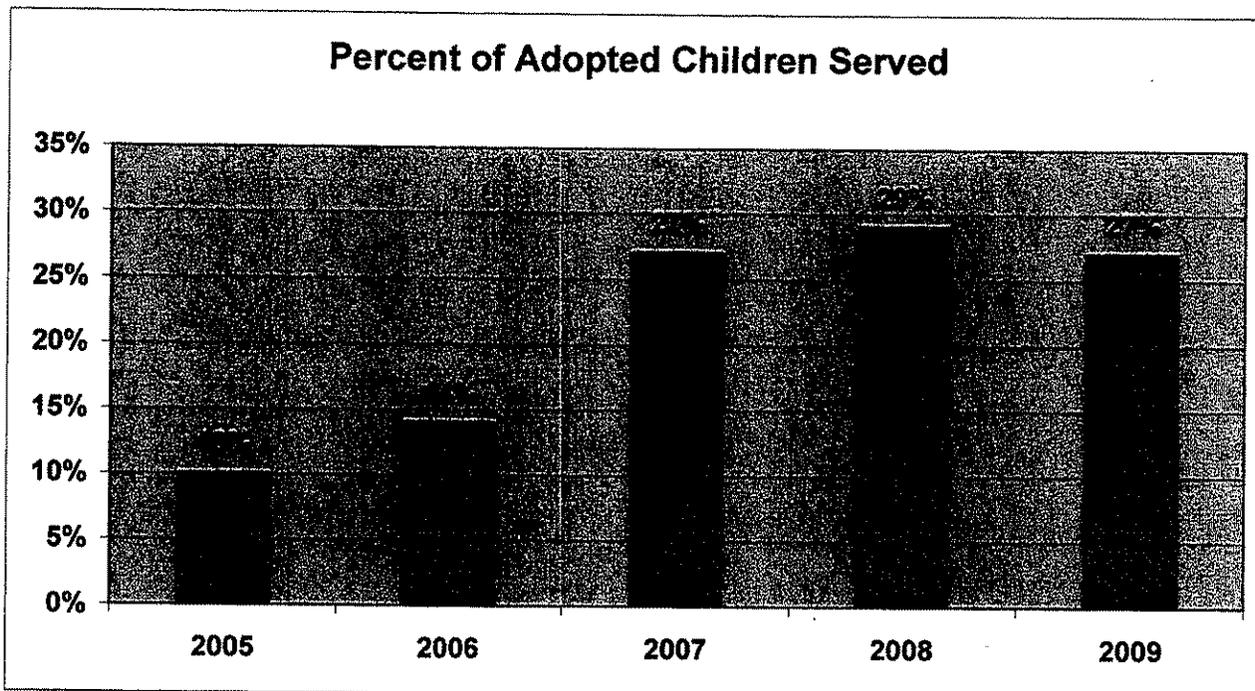


- Akron Public Schools continue to be the major school district of origin.
- Other includes referrals from: Hudson, Nardon, Revere, and Copley which comprise the other 14%.

13. Youth's Educational Placement at Time of Referral

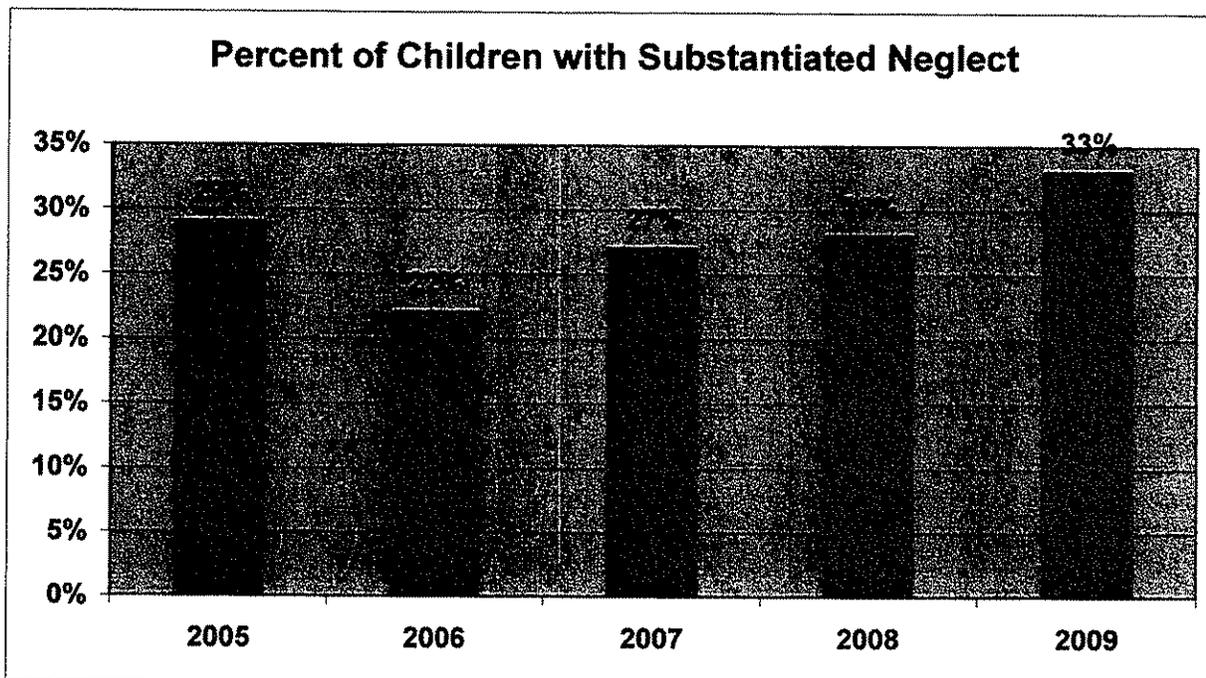


14. Percent of Adoptive Youth Referred



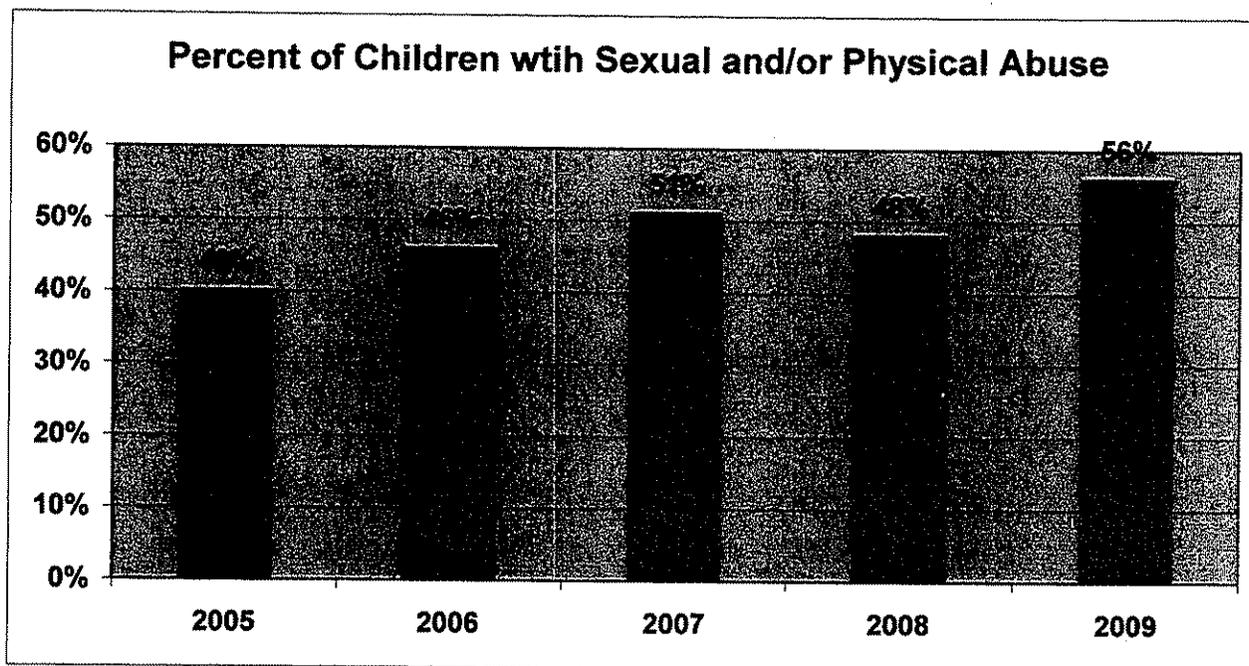
- 18 youth or 27%: male 10 (56%), female 8 (44%)
- Age range 10.8 years to 17.7 years

16. Percent of Youth Who Were Neglected (Substantiated Neglect)



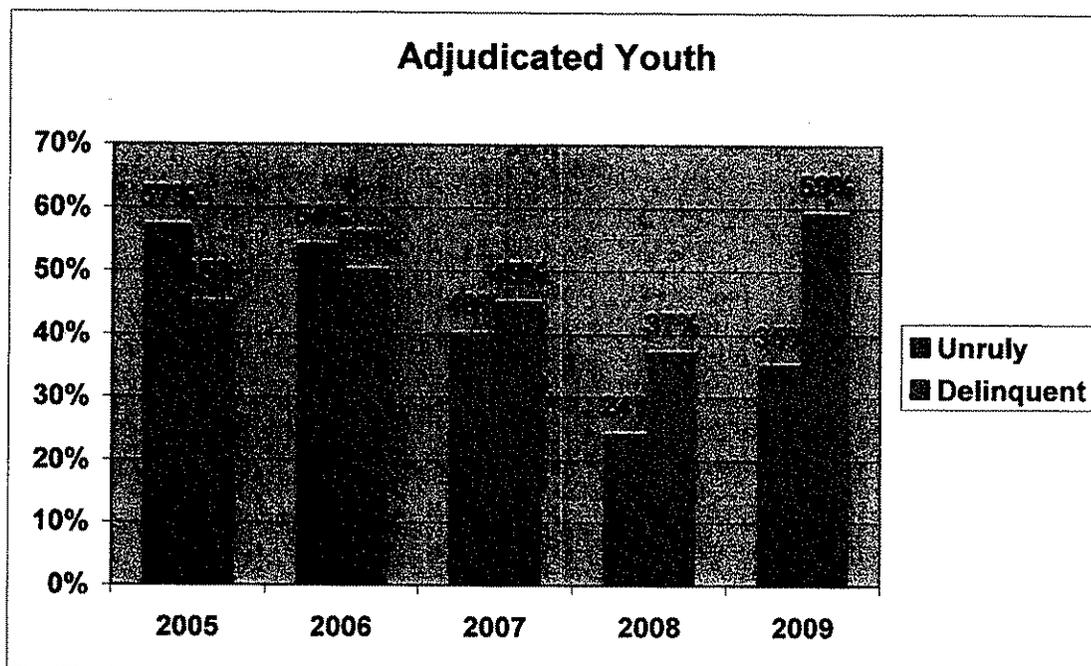
- 22 youth or 33%: Male 11 (50%), Female 11 (50%).

16. Percent of Youth Referred Who Have Been Abused (Substantiated Physical and/or Sexual Abuse)



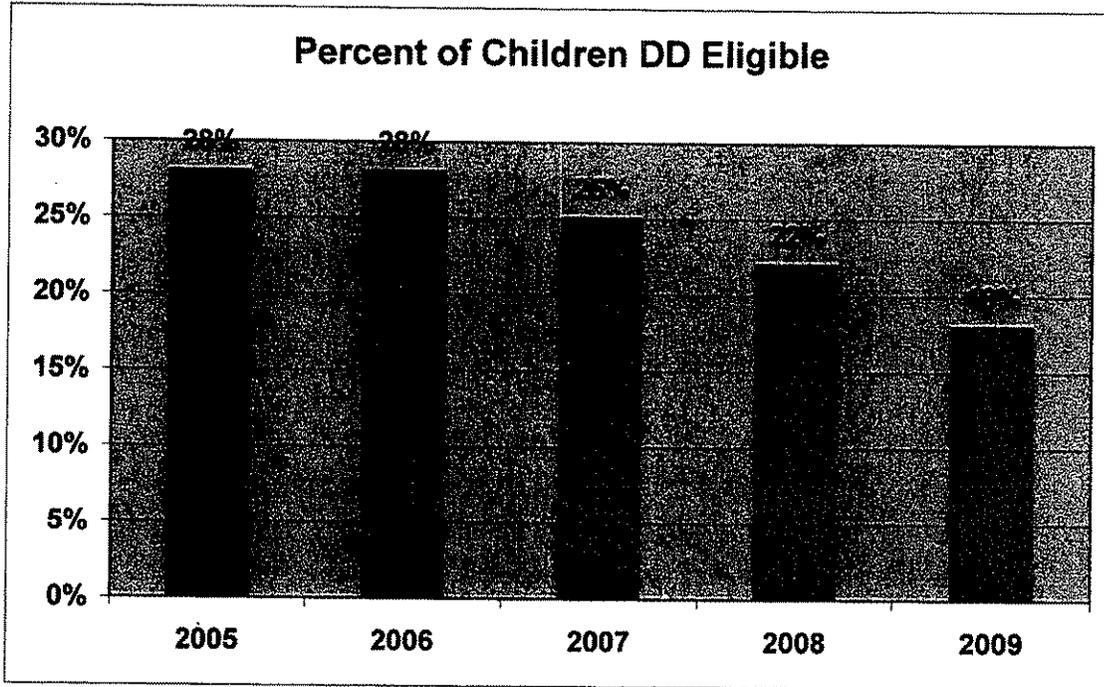
- Physical Abuse – 19 or 29%: Male 12(63%), Female 7 (37%)
- Sexual Abuse – 18 or 27%: Male 8 (44%), Female 10 (56%)

17. Percent of Youth Referred Who Had One or More Unruly and/or One or More Adjudicated Delinquent Charges. (Youth May Be Counted in Both Categories)



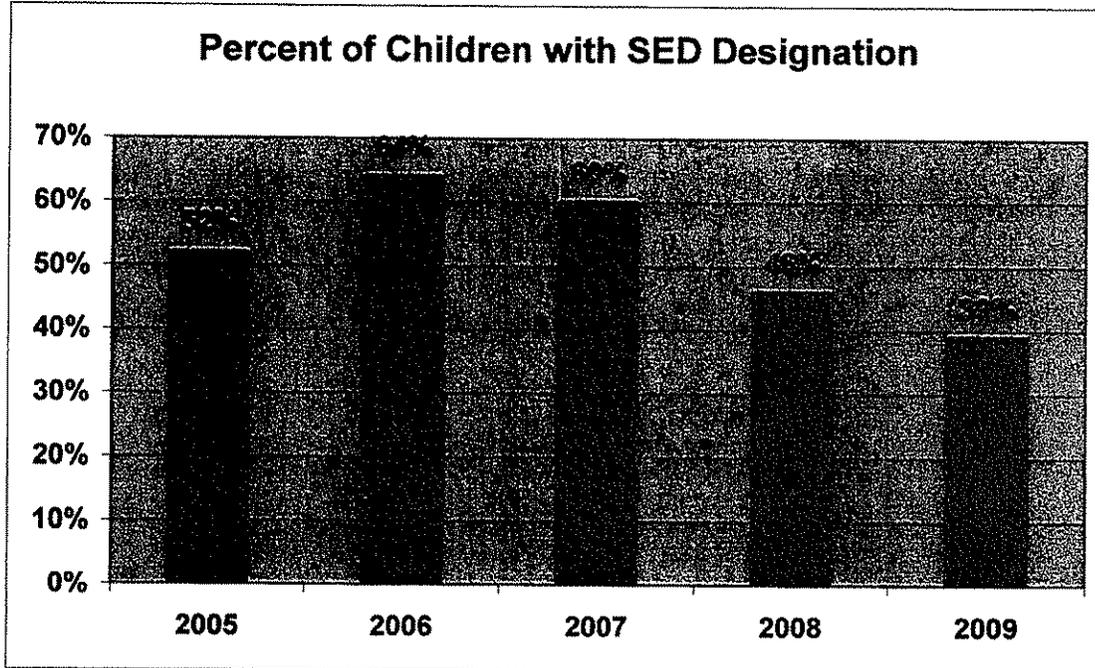
- Delinquent – 39 or 59%: Male 24 (62%), Female 15 (38%)
- Unruly – 23 or 35%: Male 12 (52%), Female 11 (48%)

18. **Percent of Youth Who are DD Eligible Based on the COEDI (Ohio Eligibility Determination Instrument)**



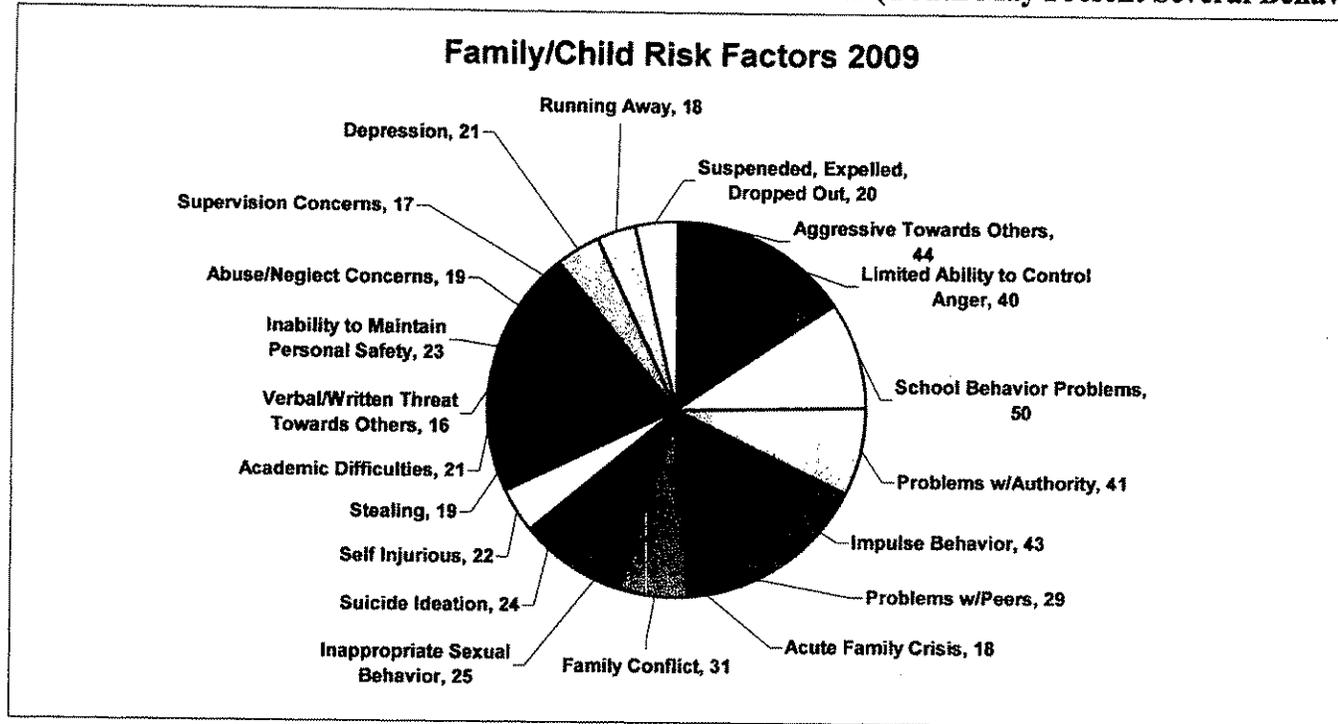
- 12 youth or 18%: Male 10 (83%), Female 2 (17%)

19. **Percent of Youth Who are SED (Severely Emotionally Disturbed)**



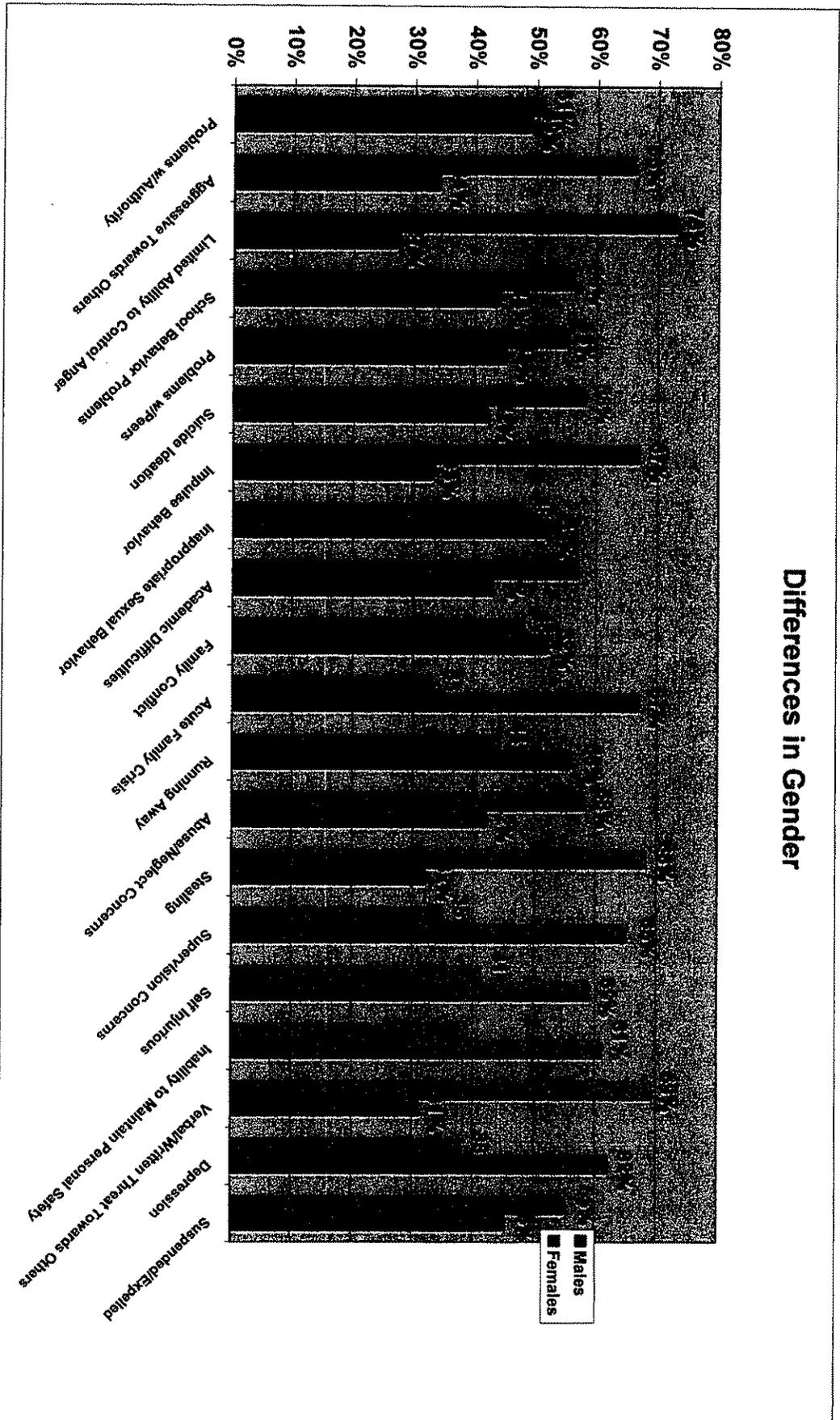
- 26 youth or 39%: Male 14 (54%), Female 12 (46%)

20. Primary Presenting Behaviors in 2009 at Time of Referral (Youth May Present Several Behaviors)

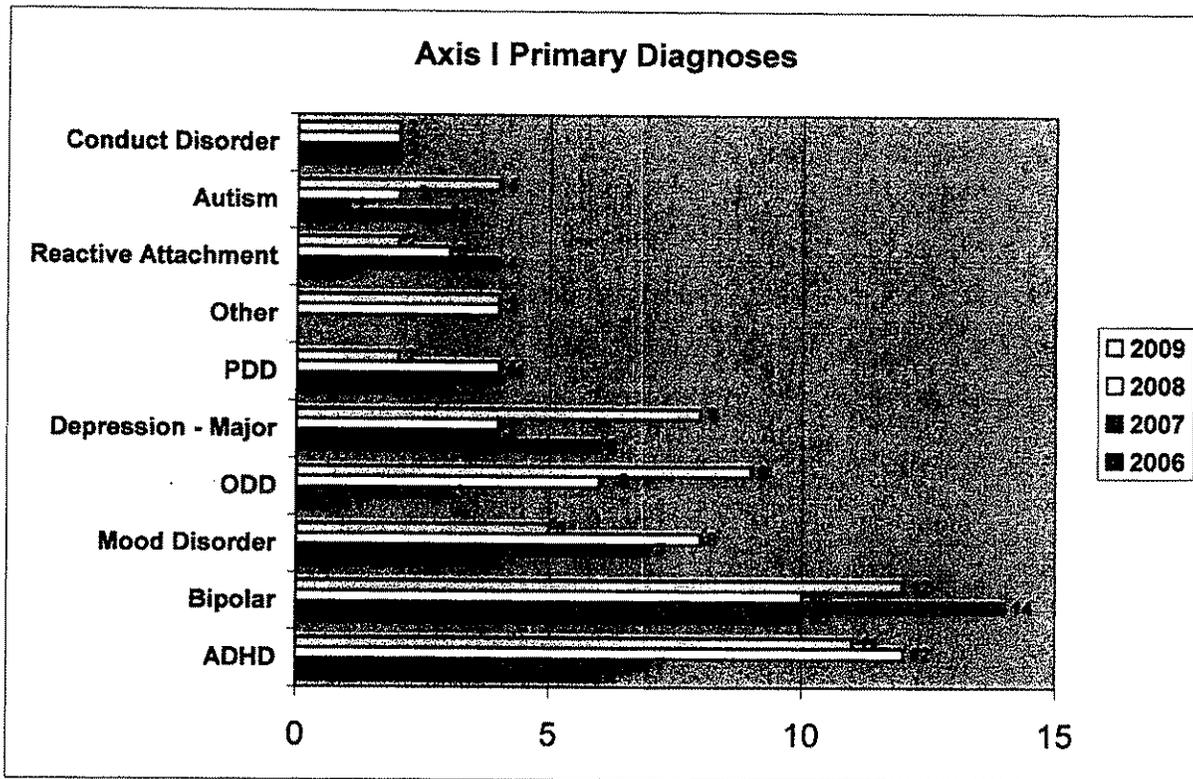


21. Differences in Gender for 2008:

Differences in Gender

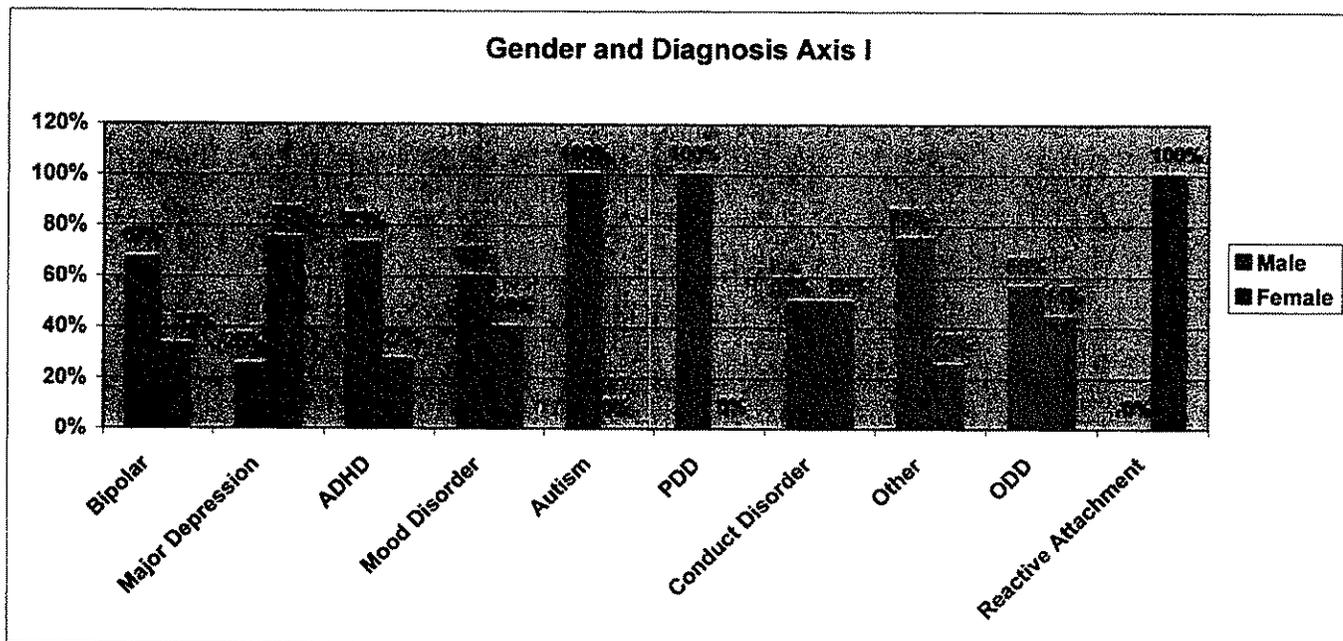


22. **Mental Health Diagnoses for 2009 at the Time of Referral (Youth May Have More Than One Diagnosis).**

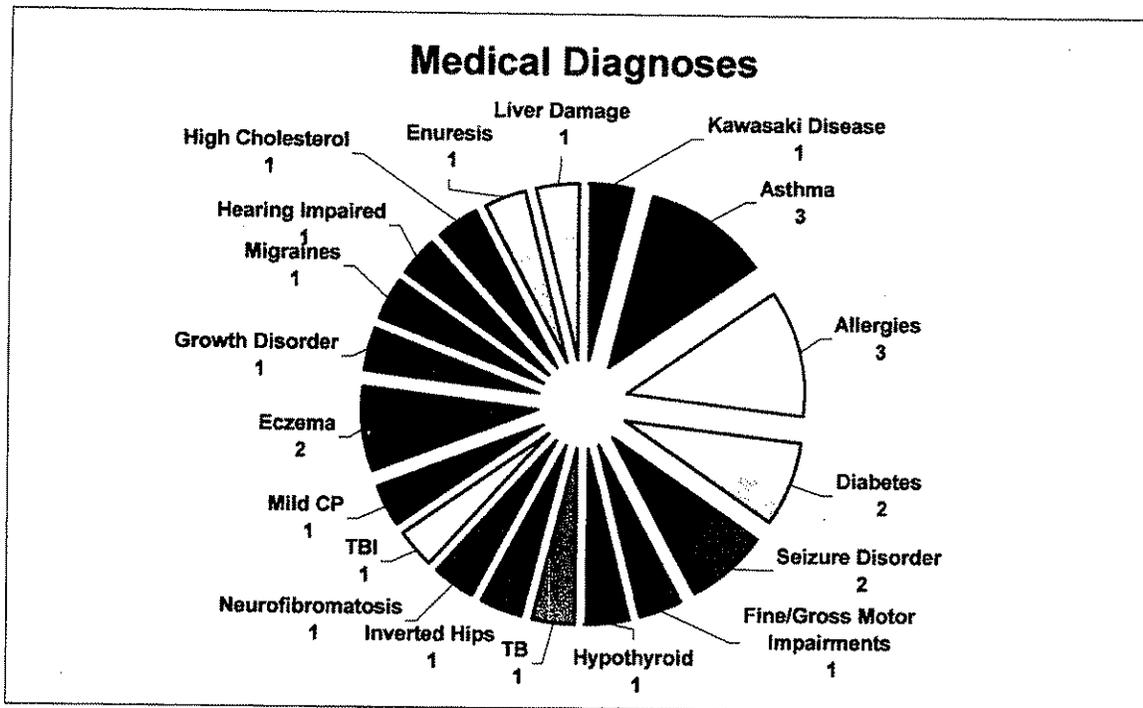


- Most frequent diagnosis in the last 5 years has been Bipolar
- In 2008 ADHD was the number one diagnosis

26. **Gender and Diagnosis 2009 Axis I:**

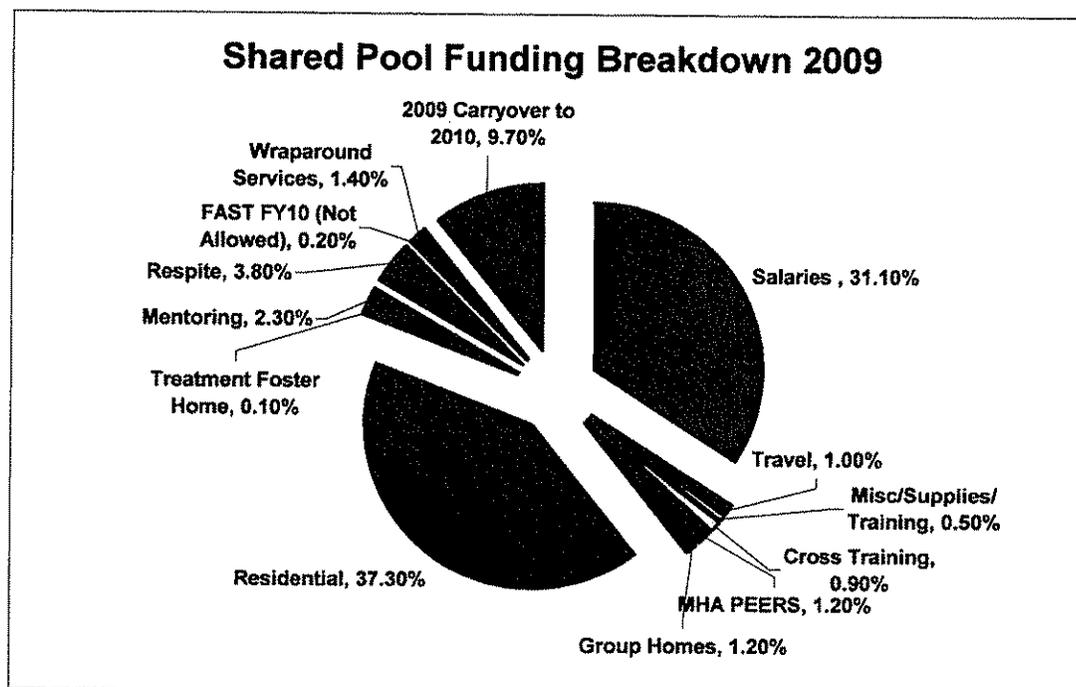


27. Medical Diagnoses 2009

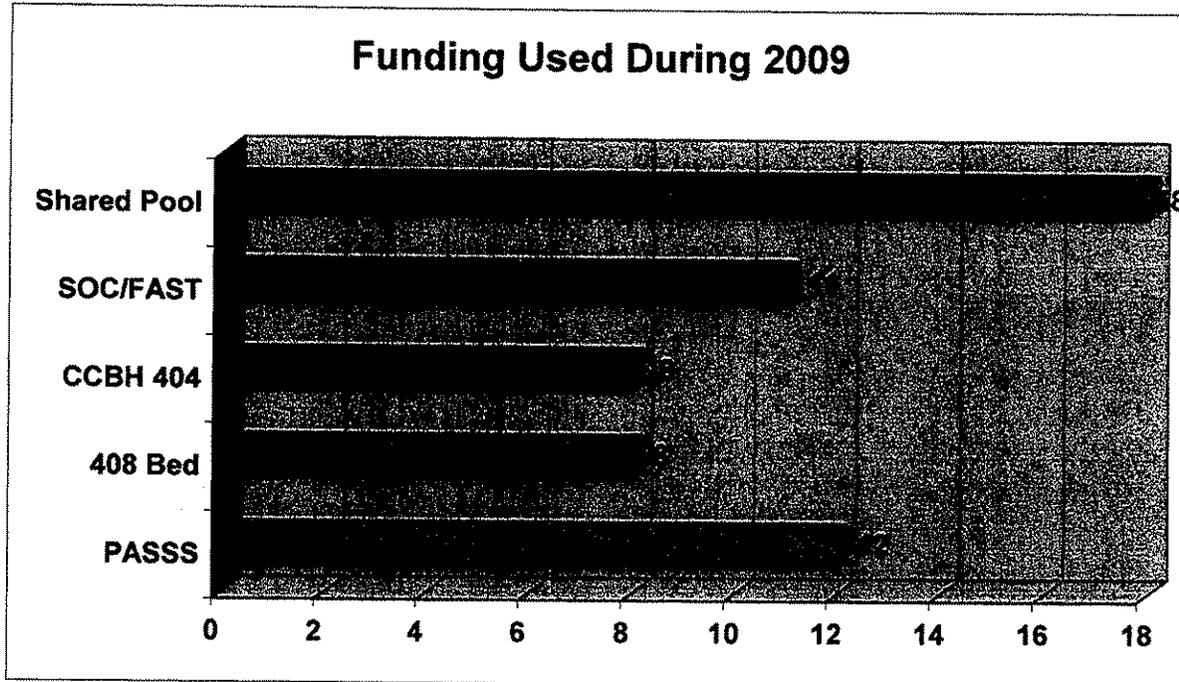


- In 2009 the Cluster had 18 youth (10 male and 8 female) diagnosed with a medical condition.
- Youth may have more than one medical condition.

25. Shared Pool Funding Breakdown 2009



26. Funding Services for 2009 Cases



- Youth may have multiple funding sources.
- There were a total of 46 youth in FY08 and 24 youth in FY09 who were enrolled in SOC/FAST for which funds were used.
- Eleven (11) youth were Cluster youth who also received SOC funding in calendar year 2009.

Definitions

PASSS: Post Adoption Special Services Subsidy was developed to assist families in the post-finalization of adoption. It was recognize that, at the time of finalization, many families are not aware of special needs that will surface in later years.

408 Mental Health: Child Guidance & Family Solutions contracts with Parmadale to provide 3 beds on their locked unit for children who are actively at risk to themselves or others.

ABC 404: Funds can be used for wrap around or short term residential placement.

FAST: FAST funds are General Revenue Funds and Federal Part B dollars. Funds are to be used to prevent youth from going into placement. Funds may only be used for children with a mental health diagnosis.

Shared Pool: Summit County's four placing agencies, Children Services, DD, Juvenile Court and Child Guidance each year contribute funds to a central account to use for youth with multiple problems and involvement with two or more systems.



**Summit Family &
Children First Council**

**SOC: Family-Centered Services & Supports
Referral Form**

IDENTIFIED YOUTH

Date Referral Made: _____

Youth Name: _____ Date of Birth: _____

Social Security Number: _____ Sex: Female Male Race _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Current School: _____ Grade: _____ Regular Ed Special Ed

Current diagnoses: _____

Current Medications: _____

PARENT/GUARDIAN INFORMATION

Name: _____ Relationship to Youth: _____

Home Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Employer: _____ Work Hours: _____

of Members in Household? _____

Sibling: _____	Age: _____	Sibling: _____	Age: _____
_____	_____	_____	_____
_____	_____	_____	_____

Referent Name: _____ Agency: _____ Phone: _____ Email: _____

**SOC: Family-Centered Services & Supports
Referral Form**

Is youth at risk for placement out of the home? YES NO
 Is youth in need of transition/step-down services back to the community? YES NO
 Is youth/family in need of support and/or services to maintain the youth in the home/community? YES NO

Reason Referred for Services or Supports? _____

Strengths of Youth and Family: _____

Current Problems/Concerns/Needs: _____

CURRENT YOUTH INVOLVEMENT LAST 30 DAYS (check all that apply)		
<input type="checkbox"/> Juvenile Court	<input type="checkbox"/> Children Services	<input type="checkbox"/> Hospital
<input type="checkbox"/> Detention	<input type="checkbox"/> Referrals	<input type="checkbox"/> Medical
<input type="checkbox"/> Probation	<input type="checkbox"/> Voluntary Case Plan	<input type="checkbox"/> Mental Health-Psych
<input type="checkbox"/> DYS Parole	<input type="checkbox"/> Custody	<input type="checkbox"/> MRDD
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Protective Supervision	
<input type="checkbox"/> Outpatient Counseling	<input type="checkbox"/> Substance Abuse Treatment	<input type="checkbox"/> Respite (out of home)
<input type="checkbox"/> Medication Management	<input type="checkbox"/> Outpatient	
	<input type="checkbox"/> Inpatient	

YOUTH CONCERNS/NEEDS		
<input type="checkbox"/> Alcohol/Drug	<input type="checkbox"/> Child Abuse	<input type="checkbox"/> Child Neglect
<input type="checkbox"/> Delinquent	<input type="checkbox"/> Developmental Disabilities	<input type="checkbox"/> Mental Health
<input type="checkbox"/> Physical Health	<input type="checkbox"/> Poverty	<input type="checkbox"/> Special Education
<input type="checkbox"/> Unruly	<input type="checkbox"/> Other	<input type="checkbox"/> Other

Other Agencies/Workers involved: (Name, Agency, phone number, Email address)

Send Referral and Release of Information To:
 Charity Hawkins
 SOC Service Coordinator
 1100 Graham Rd. Circle
 Stow, OH 44224
 Phone: 330-926-5671
 Fax: 330-923-1350
 chawkins@schd.org

Date referral received: _____



Summit Family & Children First Council

CONSENT TO EXCHANGE CONFIDENTIAL INFORMATION

CLIENT'S NAME: _____ **DATE OF BIRTH:** _____

I, _____ (relationship to client) _____, authorize:

Akron Public Schools

Child Guidance & Family Solutions **

Children's Hospital Medical Center of Akron

Summit County Children Services

Summit County Health Department

The ARC of Summit and Portage Counties

County of Summit Developmental Disabilities Board

Summit County Alcohol, Drug Addiction and Mental Health Services Board *

Regional Office of the Ohio Department of Youth Services

Summit County Educational Services Center

Summit County Juvenile Court

Mental Health America of Summit County

PEERS

OTHER AGENCIES/PERSONS:

- 1. _____ 2. _____
- 3. _____ 4. _____

TO DO THE FOLLOWING:

- Share identifying information across child-serving agencies and systems for the benefit of service coordination and service delivery for the child and family. Identifying information: name, birth date, sex, address, telephone numbers, social security number.
- Share General Medical: Medical records (except for HIV, AIDS) disability, type of services being received and name of agency providing services.
- Share Social History: Treatment/service history, psychological evaluations and other personal information regarding the individual named above.
- Share School Information: grades, attendance records, IEP (individual education plan), MFE (multi factored evaluation), IFSP (individualized family service plan), COEDI (children's Ohio eligibility determination instrument), OEDI (Ohio eligibility determination instrument – adult), transition plans and vocational assessments regarding the individual named above.
- Share Financial Information: public assistance or other financial eligibility and payment information.
- Measure Outcomes.
- Share Alcohol/Drug Abuse Services: you may limit the release to the following as desired: Check information that you wish to release: **Client (child) AND parent/guardian must initial each one.**

- _____ Diagnostic Information
- _____ Evaluation/Assessments
- _____ Treatment Plan
- _____ Ongoing Communication to Facilitate Services

- _____ Psychosocial History
- _____ Outcome of Treatment
- _____ Recommendations

NOTICE

PROHIBITION ON REDISCLOSURE OR INFORMATION CONCERNING CLIENTS IN ALCOHOL OR DRUG ABUSE TREATMENT

*This information has been disclosed to you from records protected by federal confidentiality rules. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Drug abuse patient records are also protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. parts 160 and 164. (These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.) The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**I understand and acknowledge that this Authorization extends to all or any part of the records designated above, which may include treatment for mental illness (ORC5122.31), alcohol/drug use and/or abuse, (42 CFR Part 2), and/or Human Immunodeficiency Virus (HIV/Acquired Immune Deficiency Syndrome AIDS) test results or diagnoses (ORC3701 24.3).

I understand that knowledge so obtained will be treated in a confidential manner. A photostatic copy of this authorization shall be considered valid. **This consent (unless expressly revoked earlier) expires when the case is terminated from FCFC Service Coordination.**

This form has been fully explained to me and I certify that I understand its contents.

Signature: _____ Date: _____
(Parent/Guardian or Person Authorized to Consent)

Witness: _____ Date: _____

If choosing to REVOKE, complete the following section:	
Written Revocation: I wish to cancel this Release effective: (give date)	_____
	Date
_____	_____
Parent/Guardian or Person Authorized to revoke consent	Date
_____	_____
Witness	Date

Addendum D



**Summit Family &
Children First Council**

**SOC
Strengths, Needs and Culture**

Family Name: _____

Date: _____

Participants: _____

Team identified following strengths: _____

Team identified following needs: _____

Priority needs:

1. _____
2. _____
3. _____

What is your family's culture? (What makes your family special? What is important to your family?) _____



**Summit Family &
Children First Council**

SOC: Family-Centered Services & Supports

**Individual Family Service Coordination
PLAN**

Family Name: _____

Date: _____

Participants: _____

New identified strengths or needs: _____

Measurable goals: _____

PLAN:

- 1.
- 2.
- 3.
- 4.
- 5.

Next SOC meeting: _____
Date
Time
Place

 Charity Hawkins
 SOC Coordinator



Crisis/Safety Plan

Family Name: _____ **Date:** _____

System of Care (SOC) Service Coordinator: _____

Describe the crisis behavior or situation in detail, what does it look like?

Who is involved in the crisis?

Are there other activities going on in the environment that make the situation better or worse?

List the triggers that lead to the crisis:

How often does the crisis occur? (choose best option)

Daily _____

How many times? _____

Weekly _____

How many times? _____

Monthly _____

How many times? _____

Other _____

How many times? _____

<p>Why do you think the crisis continues to happen? What is this individual getting from the crisis:</p>
<p>When triggers <u>start</u> what can you do to <u>prevent</u> the crisis from happening?</p>
<p>What can the youth do instead of the crisis behavior?</p>
<p>If the <u>crisis occurs</u> what do I do: (Detailed, sequential action steps to be followed by the team). Include who (natural & formal supports) will do what, when and how often:</p>

When: (name and action/thought) _____

_____ Is to:

1. _____
2. _____
3. _____
4. _____

_____ Is to:

1. _____
2. _____
3. _____
4. _____

If this does not work, follow the phone tree:

1. _____
2. _____
3. _____

I assisted with the creation of and agree with the contents of this plan:

Parent Signature: _____

Date: _____

Parent Signature: _____

Date: _____

Youth/Child Signature: _____

Date: _____

Worker Signature: _____

Date: _____

Service Coordinator Signature: _____

Date: _____



Ohio Family and Children First Initiative

Ohio Help Me Grow

Child Information and Referral Data Collection form

ET ID: _____

Name: _____

D.O.B.: ____/____/____

Addendum A

Child Demographic Information:

*Child's Last Name		**Child's First Name		Child's Middle Name	
** Birth Date	** Due Date	Child SSN	** Sex <input type="checkbox"/> F <input type="checkbox"/> M	** Ethnicity <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Cuban	<input type="checkbox"/> Hispanic <input type="checkbox"/> Mexican/ Mexican American/ Chicana <input type="checkbox"/> Other Hispanic/Latino <input type="checkbox"/> Puerto Rican
** Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Black or African American		<input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Guamanian or Chomorro <input type="checkbox"/> Japanese	<input type="checkbox"/> Korean <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Asian <input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> Samoan <input type="checkbox"/> Vietnamese <input type="checkbox"/> Unknown (must pick at least one other) <input type="checkbox"/> White	

Primary Caregiver Information

Does the primary caregiver have other children in HMG? <input type="checkbox"/> Yes <input type="checkbox"/> No	*Primary Caregiver Last Name	*Primary Caregiver First Name	Primary Caregiver Middle Name	
Primary Caregiver Birth Date	Primary Caregiver SSN	*Primary Caregiver Primary Phone <input type="checkbox"/> No Phone	Primary Caregiver Secondary Phone	
*Relationship to Child <input type="checkbox"/> Mother <input type="checkbox"/> Foster Parent <input type="checkbox"/> Father <input type="checkbox"/> Grand Parent	<input type="checkbox"/> Other Caregiver <input type="checkbox"/> Step Parent	<input type="checkbox"/> Surrogate Parent <input type="checkbox"/> Adoptive Parent	*Primary Language	Interpreter Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No
*Street Address Line 1	*Street Address Line 2	*City	State OH	*Zip Code

Other Caregiver Information

Does this caregiver have other children in HMG? <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Caregiver Last Name	Other Caregiver First Name	Other Caregiver Middle Name	
Other Caregiver Birth Date	Other Caregiver SSN	Other Caregiver Primary Phone <input type="checkbox"/> No Phone	Other Caregiver Secondary Phone	
Relationship to Child <input type="checkbox"/> Mother <input type="checkbox"/> Foster Parent <input type="checkbox"/> Father <input type="checkbox"/> Grand Parent	<input type="checkbox"/> Other Caregiver <input type="checkbox"/> Step Parent	<input type="checkbox"/> Surrogate Parent <input type="checkbox"/> Adoptive Parent	Primary Language	Interpreter Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Street Address Line 1	Street Address Lie 2	City	State	Zip Code

Referral Information:

*Date of Referral	*Referral Source Type <input type="checkbox"/> CAPTA (Part C) <input type="checkbox"/> Child Care <input type="checkbox"/> Children's Protective Services <input type="checkbox"/> Community Screening <input type="checkbox"/> Family Member <input type="checkbox"/> For Profit Community Provider <input type="checkbox"/> Friend	<input type="checkbox"/> GRADS Program <input type="checkbox"/> Head Start <input type="checkbox"/> Help Me Grow <input type="checkbox"/> Hospital <input type="checkbox"/> Hospital Child Find Specialist <input type="checkbox"/> Human Services <input type="checkbox"/> LEAP	<input type="checkbox"/> Legal <input type="checkbox"/> Local Health Dept. <input type="checkbox"/> Local Preschool <input type="checkbox"/> Mental Health Agency <input type="checkbox"/> County Board of DD <input type="checkbox"/> Nonprofit Com. Provider <input type="checkbox"/> OCCSN <input type="checkbox"/> ODH BCMH	<input type="checkbox"/> Physician <input type="checkbox"/> Primary Caregiver <input type="checkbox"/> Public Health Nurse <input type="checkbox"/> Public School <input type="checkbox"/> Regional Infant Hearing <input type="checkbox"/> State Health Dept. <input type="checkbox"/> WIC
** Referrer Name	** Referral Source Name	Referrer Email	*Referrer Phone <input type="checkbox"/> No Phone	Referrer Fax
*Referral To Category <input type="checkbox"/> Suspected H.V. Elig. <input type="checkbox"/> Suspected Part C <input type="checkbox"/> Unknown	** Referrer Street Address Line 1	** Street Address Line 2	** Referrer City	** State
Referral Reason	*Referral Contact Date:	*Referral Contact Method: <input type="checkbox"/> In person <input type="checkbox"/> Letter	<input type="checkbox"/> Phone <input type="checkbox"/> No Contact	*Contact Outcome <input type="checkbox"/> Response <input type="checkbox"/> Mailed <input type="checkbox"/> No Response Info
** Referral Outcome Date	** Referral Outcome <input type="checkbox"/> Assign a SC/HV/Agency <input type="checkbox"/> Child already referred	<input type="checkbox"/> Child/family referred w/in 45 days of 3 rd birthday <input type="checkbox"/> Child/family could no longer be located	<input type="checkbox"/> Family not interested <input type="checkbox"/> Child/family not eligible for Home Visiting Program	

*Required

**Conditional Requirements

Use of this form is required and it must be kept in child records.

Created: June 2010



Consent to Release or Share Information

I, _____, parent/guardian and legal custodian of _____, born on _____,

do hereby give the Help Me Grow program and the agencies and systems initialed below permission to share information/confidential Help Me Grow records among one another for the purpose of service planning for my child and family.

Information may be released or shared with the following:

<u>Name</u>	<u>Parent/Guardian Initials</u>	<u>Date</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

The following information may be released or shared:

Initials/Date

- Medical records (includes medical, hospital, discharge summaries, vision/hearing/nutrition status) _____
- Diagnosed physical or mental condition/statement of nature and severity of disability _____
- Immunization records _____
- IFSPs (to include all updates) _____
- Family Plans (to include all updates) _____
- Therapy records, evaluation, goals _____
- Public health nurse assessment _____
- Developmental assessments, screenings and summaries _____
- Social security number/case number _____
- Other (specify) _____
- Other (specify) _____

Purpose of information requested: _____

Health Insurance Portability and Accountability Act (HIPAA)
Family Education Rights and Privacy Act (FERPA)

Any and all personally identifiable information regarding children and families receiving Help Me Grow services is protected from unauthorized disclosure under FERPA. Personally identifiable information protected by FERPA is specifically exempted from HIPAA privacy standards. FERPA prevents the disclosure of personally identifiable information without parental consent except in limited circumstances, requires notice to be provided to the child's family regarding their privacy rights, requires providers to keep records of access to child's records and contains complaints and appeal procedures which apply to disputes over records in possession of Help Me Grow providers among other provisions. All Help Me Grow providers comply with these procedures.

Complete the following if applicable:

You may limit the information to be released or shared with agencies or providers but are not required to do so.

Not applicable

I, _____, limit the following agencies, providers
(Parent/Guardian)
and/or persons with whom information will be shared or released:

Agency/Provider/Person	Parent/Guardian Initials	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Explanation of Limits: _____

I do not provide consent for information to be released or shared to the following agencies, providers and/or persons:

Not applicable

Agency/Provider/Person	Parent/Guardian Initials	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

This consent expires on _____, unless consent is revoked in writing by
(Child's third birthday)
parent/guardian, or when child no longer receives Help Me Grow services.

By signing below, I certify that I have authority to the above release or share of information.

Signature Date

Witness Date

Daily Routines Interview

Addendum D

McWilliam 2003

Format revised by Family Child Learning Center 2008

Child's Name:	
Date of Birth:	
Today's Date:	

Routine (1=least satisfied, 5=most satisfied)	Notes	It would be better if... (Possible IFSP outcomes. Star the family's top priorities.)
Naptime/Bedtime/ Waking Up 1 2 3 4 5		
Diapering/Toileting 1 2 3 4 5		
Dressing 1 2 3 4 5		
Feeding/Mealtime 1 2 3 4 5		
Traveling 1 2 3 4 5		
Bath 1 2 3 4 5		
Playtime/Leisure 1 2 3 4 5		

Ohio's Individualized Family Service Plan



Help Me Grow A program of family supports and services for expectant parents, newborns, infants and toddlers and their families.

Ohio's Vision To assure that newborns, infants and toddlers have the best possible start in life.

Our vision for _____ and our family while in Help Me Grow is

Addendum E

Child's name	Date of Birth
Child lives with (name)	(Relationship)

Interpreter needed? Yes No Surrogate parent Yes No

HMG Service Coordinator	Agency
Phone	FAX
	E-mail

Family Support Specialist	Phone	E-mail
---------------------------	-------	--------

Section I: Family Information and Timelines

Primary Care Giver Contact Information

<input type="checkbox"/> Parent(s) <input type="checkbox"/> Guardian <input type="checkbox"/> Custodial parent <input type="checkbox"/> Foster parent (identify one)				Home telephone	
First Name:		Last Name:			
Address <i>street</i>		city	state	zip	Cell telephone
Native Language and / or communication method used			E-mail address		Work telephone
Interpreter needed? <input type="checkbox"/> Yes <input type="checkbox"/> No					

<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Foster Parent (identify one)				Home telephone	
First Name:		Last Name:			
Address <i>street</i>		city	state	zip	Cell telephone
Native Language and / or communication method used			E-mail address		Work telephone
Interpreter needed? <input type="checkbox"/> Yes <input type="checkbox"/> No					

Surrogate Parent				Home telephone
Address <i>street</i>		City	state	zip

Help Me Grow Timelines

Date of referral to HMG for ongoing services	Date of suspected delay (when applicable)	Date of developmental screening (not applicable if there is a diagnosed physical or mental condition)	Date determined eligible for ongoing HMG services
Initial IFSP	IFSP review	Annual review	IFSP reviews
School District / LEA		Initial Transition Plan date	Transition Planning Conference date
Early Track ID numbers	BCMH number	Social Security number	Medicaid number
Healthy Start / CHIP number	Primary Insurance		

Section II: Health and Medical Information

Child's Medical home: The doctor's office, health center or other place, you regularly take your child for check-ups, shots, or illness.

Name			Phone
Mailing Address			FAX
City	State	Zip	E-mail

Child's General Health (physical, emotional, behavioral) including: significant family, prenatal, medical or birth history or hospitalizations:

Dates of child's last well child check up?	2.	3.	4.
Are Immunizations: <input type="checkbox"/> up to date <input type="checkbox"/> late up to date <input type="checkbox"/> not up to date <input type="checkbox"/> not medically recommended			
Are there any concerns about your child's dental health? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, specify</i>			
Are there any concerns about your child's sleep patterns? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, specify</i>			
Has your child been tested for lead? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, specify</i>			
Does your child have allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, specify</i>			
Does your child take any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, specify</i>			
Does your child see any medical specialists? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, specify</i>			
Does your child have a medical diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, specify</i>			
Does your child have a BCMH managing doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending if so, who is it?			
Updated health information (e.g. ear infections, immunizations, hospitalizations):			

Section IV: Family Concerns and Priorities

Please identify your concerns and your priorities related to enhancing the development of your child. This will assist us in developing a child or family outcome with you.

Child's name	Date of Birth
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Caregiver(s) have questions about or want help for my child in the following areas:

Caregivers want information about or help with:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Assistive technology or other equipment/supplies | <input type="checkbox"/> Language (cooing, babbling, smiling, talking and listening) | <input type="checkbox"/> Budgeting | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Behavior (helping my child calm down, be comfortable, getting along with others, biting, expresses feelings) | <input type="checkbox"/> Learning new things | <input type="checkbox"/> Childcare | <input type="checkbox"/> Linking with other parents |
| <input type="checkbox"/> Eating and drinking (sucking, breastfeeding, taking a bottle, using a spoon) | <input type="checkbox"/> Moving around (holding head up, rolling, sitting, crawling, standing, walking) | <input type="checkbox"/> Discussing emotional issues for myself and child(ren) | <input type="checkbox"/> Managing anger |
| <input type="checkbox"/> Helping my child learn to read | <input type="checkbox"/> Pain or discomfort | <input type="checkbox"/> Education for myself | <input type="checkbox"/> Meeting my child's special health care needs |
| <input type="checkbox"/> Information about diagnosis or disability | <input type="checkbox"/> Safety in our home and other places | <input type="checkbox"/> Family conflict | <input type="checkbox"/> Money for extra costs relating to my child's special needs |
| <input type="checkbox"/> Information on whether my child's condition is hereditary | <input type="checkbox"/> Self Help (diapering, toileting, dressing, sleeping, other daily routines) | <input type="checkbox"/> Finding or working with doctors or other specialists | <input type="checkbox"/> Obtaining respite care |
| | <input type="checkbox"/> Special health care needs | <input type="checkbox"/> Help with insurance | <input type="checkbox"/> Planning for the future; what to expect |
| | <input type="checkbox"/> Other | <input type="checkbox"/> Housing, clothing, jobs, food, telephone | <input type="checkbox"/> Recreation |
| | <input type="checkbox"/> Vision and Hearing (responding to what they hear and see) | <input type="checkbox"/> Ideas for siblings, friends, extended family members | <input type="checkbox"/> Safety in our home (smoke alarms, first aid supplies) |
| | | <input type="checkbox"/> Improving my parenting skills | <input type="checkbox"/> Spending time with family and friends, social interaction skills |
| | | <input type="checkbox"/> Learning how different services work and how they could work better for my family | <input type="checkbox"/> Transportation services for my child or family |

Comments / Priorities:

Section V: Everyday Routines, Activities and Places (ERAP)

It is helpful for us to know where your child regularly spends time, because young children learn best through their routines and in activities which interest them.

A. What is a typical day like for your child and family?
B. What does your child and family like to do together?
C. What does your child and family find challenging or difficult to do? (e.g. people, activities)

Section VI: **Outcome**

Number _____

Child's name	Date of birth	Date Outcome written
--------------	---------------	----------------------

What do we want to happen in the next 6 months? (refer to Section IV: **Family Concerns and Priorities**)

What's happening now? (include a pre-literacy and language skills as developmentally appropriate)

What supports and resources do I/we have available to achieve this outcome?

Who will help us and what strategy will they use so we can achieve our outcome? These strategies are to occur during our child/family's daily activities and routines. (refer to Section V: **Everyday Routines, Activities and Places – ERAP**)

After reviewing our outcome, my family and IFSP team, have decided:

My child and / or family met this outcome.

Date of IFSP Review: _____

We have partially met this outcome. Why?

The outcome was not met. Why?

--

Section VII: Help Me Grow Services and Supports
 This section is for all children receiving ongoing services to meet an outcome / goal identified in Section VI.

Child's Name _____ Date of Birth _____

Service Type	Service provider name and agency	Service location	Method C or D (Consultant, Individual or Group)	Frequency (e.g. # times per month)	Intensity (length of session)	ERAP (If No explain below)	Duration: Projected start date and end date	Actual start date	Payment Source	Outcome Number
29. Service Coordination						<input type="checkbox"/> Yes <input type="checkbox"/> No				
						<input type="checkbox"/> Yes <input type="checkbox"/> No				
						<input type="checkbox"/> Yes <input type="checkbox"/> No				
						<input type="checkbox"/> Yes <input type="checkbox"/> No				
						<input type="checkbox"/> Yes <input type="checkbox"/> No				
						<input type="checkbox"/> Yes <input type="checkbox"/> No				
						<input type="checkbox"/> Yes <input type="checkbox"/> No				
						<input type="checkbox"/> Yes <input type="checkbox"/> No				
						<input type="checkbox"/> Yes <input type="checkbox"/> No				
						<input type="checkbox"/> Yes <input type="checkbox"/> No				

ERAP

Service type	If 'No', why?	Service type	If 'No', why?
Service type	If 'No', why?	Service type	If 'No', why?
Service type	If 'No', why?	Service type	If 'No', why?
Service type	If 'No', why?	Service type	If 'No', why?

Service Types

1. Assistive Technology Services / Devices *
2. Audiological Services *
3. Child Care
4. Children's Protective Services
5. Clothing
6. Counseling
7. Dental / Orthodontic Care
8. Drug / Alcohol Counseling
9. Educational
10. Employment
11. Family Training
12. Financial Services
13. Genetic Counseling
14. Habilitative Services for Hearing Loss *
15. Health Services *
16. Home Visits
17. Housing
18. Legal
19. Medical (Diagnostic or Evaluation)
20. Nursing Services *
21. Nutrition Services *
22. Occupational Therapy *
23. Parenting Education
24. Physical Therapy *
25. Psychological / Mental Health Services *
26. Recreation / Social
27. Rehabilitation
28. Respite Care
29. Service Coordination
30. Shelter (Temporary)
31. Social Work Services *
32. Special Instruction *
33. Speech / Language Therapy *
34. Support / Self Help Group
35. Transportation
36. Vision Services *

Service Locations

1. Child Care Center
2. Clinic
3. Community Center
4. Early Childhood Center
5. EI Center / Class for Children with Disabilities
6. Family Day Care
7. Grocery Store
8. Head Start
9. Home
10. Hospital
11. Library
12. Park
13. Preschool
14. Regular Nursery School
15. Residential facility
16. Restaurant

*Early intervention specialized services covered under the OBH / BEIS Early Intervention System of Payment.

Section VIII: Transition at Age Three Outcome

Child's name	Date of birth
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A. What do we want to happen before _____ turns three and leaves Help Me Grow?
(e.g. preparing the child and family for change and identifying possible options)

What program are we interested in for _____ once he turns 3 ?

B. Who will help us and what strategy will they use so we can achieve our goal to ensure a smooth transition?

C. After reviewing our transition goal, my family and IFSP team (and the LEA, if applicable) have decided that at age three:

<input type="checkbox"/> My child and / or family met this outcome.
<input type="checkbox"/> We have partially met this outcome. Why?
<input type="checkbox"/> The outcome was not met. Why?

Section IX: Transition Documentation Checklist

Child's name	Date of birth
--------------	---------------

Italics = Child may qualify for Part B Services

Between 6-9 months prior to child's third birthday Begin preparing for the Transition Planning Conference.	Projected Date	Actual Date	Service Coordinator's Initials
1. Discuss the transition process and develop outcome(s) and activities/strategies on the Individual Family Service Plan (IFSP).			
2. Review child's progress and identify any concerns.			
3. Identify possible program options (public preschool, Head Start, preschool special education, childcare, other)			
4. Identify participants for the Transition Planning Conference. <i>If the child is suspected of having a disability at age 3, the LEA representative, with parental permission, must be invited to attend the transition planning conference.</i>			
5. Obtain informed written parental consent to invite identified participants to the Transition Planning Conference (TPC).			
6. Obtain written parental consent for the release of information/records. (Specify what records are to be released and to whom).			
7. Determine mutually agreed upon time and date for Transition Planning Conference (90 days or up to 9 months before the child's third birthday).			
8. Send each identified individual / agency written notification of the Transition Planning Conference including the date, time and location.			

At least 90 days prior to the child's third birthday, conduct the Transition Planning Conference with invited participants.	Projected Date	Actual Date	Service Coordinator's Initials
1. Discuss transition process, review and update the Transition outcome to ensure a smooth transition by age three.			
2. <i>The LEA / School district representative will:</i>			
<i>a. Inform family of the due process and procedural safeguards.</i>			
<i>b. Review child's records.</i>			
<i>c. Decide with family and other team members if there is a suspected disability, as defined by Part B.</i>			
3. <i>If a disability is suspected, complete a Referral for Evaluation PR-04.</i>			
4. <i>Obtain written parental permission for a multi - factored evaluation (MFE) using the Parent Consent for Evaluation Form PR-05.</i>			
5. <i>If a disability is not suspected the team explores other community and program options for the child at age 3.</i>			

Section X: IFSP Signatures and Consents

Child's name	Date of birth
--------------	---------------

Please check all that apply:

- I participated fully in the development of this plan and give my consent to implement the IFSP.
- I have been given and understand my parental rights under Help Me Grow.
- I understand my child is eligible for additional rights under Part C of IDEA.
- I understand I can ask the team and anyone else to meet to make changes to this IFSP at any time.
- I consent to provide a copy of the following sections of my IFSP to _____
 - All sections
 - Only sections _____
- I consent to provide a copy of this IFSP to my IFSP team

Parent/Guardian/Surrogate Parent signature	Date
--	------

To be noted prior to the Transition Process :

For Part C eligible children in HMG, notification that includes the names, address, birth date, parent(s) name(s), and telephone number, will be sent to the LEA/school district informing the district that the child may be eligible for Part B services at age 3 years. This notification is a requirement of Part C of the Individuals with Disabilities Education Act (IDEA) and is beneficial in preparing the school district of the child's possible eligibility for special education preschool services. *Opting out of this notification must be obtained at the IFSP meeting closest to the child becoming 18 months old or immediately upon entry into HMG if the child enters after 18 months of age.* Opting out of this notification must be recorded below with check box and parent signature.

- I have been informed of the notification requirement and choose **NOT** to have the above identified information sent to the LEA.
 Parent Signature _____ Date _____

For children who may be eligible for Part B pre-school services and supports, attendance by a representative from the school district at the Transition Planning Conference is essential to the transition process and preparation for the exit from HMG .

- I give consent to have a school district representative attend my child's Transition Planning Conference.
 Parent Signature _____ Date _____

IFSP Team member's Approval of Plan:

We agree that the goals/outcomes selected reflect the family's priorities and concerns and the strategies selected support those goals. We agree to carry out the plan in a manner that supports the family's ability to help their child participate in and learn from their everyday routines and activities whenever possible.

Signature (or printed name if not in attendance)	Title / Role / Agency	Method of Participation	Date
	Service Coordinator	Present	

*Method includes present (P) Written (W) Conference Call (C)

**SUMMIT FAMILY & CHILDREN FIRST COUNCIL
2010-2011 MEMBERSHIP ROSTER**

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