

Family Choice/Confirmation

I, _____ parent/guardian of _____

understand that the following services are available for my child. These services are delivered in accordance with the Child Adolescent Service System Program (CASSP) Principles which are child centered, community based, least restrictive, family focused, multi-system and culturally competent.

Please <input checked="" type="checkbox"/>	Have Now	Have Had	Never Had
Administrative Case Management			
Resource Case Management			
Intensive Case Management			
Psychological Evaluation			
Psychiatric Evaluation			
Medication Management			
Child/Family Outpatient Counseling			
Partial Hospitalization			
Family-Based Mental Health			
Behavioral Health Rehabilitation			
<i>Community Based</i>			
<i>Residential</i>			
<i>Other</i>			

Other services have been tried and/or I do not believe they would meet the needs of my child at this time. I agree that Behavioral Health Rehabilitation Services is the best choice of services at this time.

I have been made aware of the choice of providers at this time and have chosen _____ as our provider at this time. I have also been advised that a new provider can be chosen at any time and that the above-named provider will assist me in making such a change.

Parent/Legal Guardian Date _____

Child/Adolescent (14 or older) Date _____

Case/Care Manager Date _____

Provider Representative Date _____