Interagency Meeting and Case Report Form
2018

## Interagency Review Team Introduction

**Each agency will protect the rights of children with respect to records created, maintained, and used by public institutions and contracted providers with the state. Applicable laws and regulations for these rights shall be strictly followed.**

**Each agency shall ensure that its contract providers for services affected by this Agreement shall include provisions for confidentiality of records and information.**

**I agree to treat all information about clients or former clients and their families that I learn during the performance of my duties as a member of the local, state, or regional review team as confidential. I understand that it would be a violation of policy to disclose such information to anyone without**
**supervisory approval.**

***Continuation of this survey implies acknowledgement of the review team's confidentiality expectations.***

Interagency Meeting and Case Report Form
2018

## Review Team Meeting Information

* 1. Interagency Review Team Leader Contact Information

**Name** ______

**Agency** ______

**Email Address** ______

**Phone Number** ______

* 2. Is this report for a **County Review Team, Local Review Team, Regional Review Team, or Statewide Review Team**?

## Interagency Meeting and Case Report Form 2018

### Circuit

* 3. Please select the Local Review Team's circuit (county review team is counted as a local review team)?

Interagency Meeting and Case Report Form 2018

### Region

* 4. Please select the Regional Review Team's region.

Interagency Meeting and Case Report Form 2018

### Meeting/Case Staffing Representation

* 5. Which agencies were represented at this meeting or case staffing? (Select all that apply)

- [ ] Agency for Health Care Administration (AHCA)
- [ ] Agency for Person's with Disabilities (APD)
- [ ] Care Management Organization (CMO)
- [ ] Child Protection Team
- [ ] Children's Legal Services (DCF)
- [ ] CINS/FINS
- [ ] Community Action Team (CAT)
- [ ] Community Based Care (CBC)
- [ ] DCF Residential Provider
- [ ] Department of Children and Families-Child Welfare (DCF-CW)
- [ ] Department of Children and Families-Other (DCF-Other)
- [ ] Department of Children and Families-Substance Abuse and Mental Health (DCF-SAMH)
- [ ] Department of Education (DOE)
- [ ] Department of Health (DOH)
- [ ] Department of Juvenile Justice (DJJ)
- [ ] DJJ Residential Provider
- [ ] Florida Office of Early Learning (FOEL)
- [ ] Guardian Ad Litem (GAL)
- [ ] Local Behavior Health Care Provider
- [ ] Local Health Care Provider
- [ ] Local Mental Health Care Provider
- [ ] Local School Representative
- [ ] Local Substance Abuse Care Provider
- [ ] Managing Entity (ME)
- [ ] MMA Plan (Medicaid Managed Care)
- [ ] Office of State Attorney
- [ ] Office of the Public Defender
- [ ] Parents/ Caregivers
- [ ] Psychiatric Receiving Facility/ CSU
- [ ] SEDNET
- [ ] SIPP Provider
- [ ] Other/Provider (Please specify additional providers or stakeholders' organization names. Please separate responses by a semicolon, ";")

Interagency Meeting and Case Report Form
2018

## Case Staffing or Meeting Report

* 6. Did your review team staff any cases?

## Interagency Meeting and Case Report Form 2018

### Youth Information

7. Please insert the Youth's DJJ unique identifier if applicable (JJIS).

8. Please insert the Youth's unique DCF-CW identifier if applicable (FSFN Case ID).

9. **<u>If the youth does not</u>** have a FSFN or JJIS number please indicate the Youth's first initial, last initial, and six digit date of birth mmddyy. (example Jim Thompson born September 16, 1994= JT091694).

* 10. What was the child's age at the date of staffing?

- < Less than twelve months
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18 +

* 11. What is the youth's gender?

- Male
- Female
- Other (please specify)

* 12. How is this youth insured?

- Medicaid/Medicaid Plan
- Private
- None

## Case Staffing Information

13. Please indicate the staffing date.

Date

MM/DD/YYYY

14. When was the case **referred to your review team**?

Date

MM/DD/YYYY

* 15. Which agency/agencies referred this case to your review team? (select all that apply)

- [ ] Agency for Health Care Administration
- [ ] Agency for Persons with Disabilities
- [ ] Department of Children and Families
- [ ] Department of Health
- [ ] Department of Juvenile Justice
- [ ] Education
- [ ] Guardian ad Litem Program
- [ ] Florida's Office of Early Learning
- [ ] Crossover Youth Practice Model (CYPM)
- [ ] Community Based Care
- [ ] Managing Entity
- [ ] Other **(Please specify only if the referring agency does not fit within the categories above.)**

* 16. Which of the following agencies does the youth have an open case with? (select all that apply)

- [ ] Agency for Health Care Administration
- [ ] Agency for Persons with Disabilities
- [ ] Department of Children and Families
- [ ] Department of Health
- [ ] Department of Juvenile Justice
- [ ] Education
- [ ] Guardian ad Litem Program
- [ ] Florida's Office of Early Learning
- [ ] Crossover Youth Practice Model (CYPM)
- [ ] Community Based Care
- [ ] Managing Entity
- [ ] Other **(Please specify only if the agency does not fit within the categories above.)**

* 17. Has your review team previously staffed this case?

- ( ) Yes
- ( ) No
- ( ) Other (please specify)

* 18. Is this youth involved in an open juvenile dependency case?

- ( ) Yes
- ( ) No

## Interagency Meeting and Case Report Form 2018

* 19. In home or out of home?

- ( ) In home
- ( ) Out of home

## Case/System Challenges and Needs

* 20. What individual challenges were involved in this Youth's case? (Select all that apply)

- [ ] Abandonment
- [ ] Abuse- Perpetrator
- [ ] Abuse-Victimization
- [ ] Adoption
- [ ] Autism/Autism Spectrum
- [ ] Baker Acts
- [ ] Behavioral Problem
- [ ] Chronic Mental Health
- [ ] Cross State Jurisdiction/Interstate Compact for Juveniles (ICJ)
- [ ] Domestic Violence
- [ ] Education Issue
- [ ] Homelessness
- [ ] Human Trafficking
- [ ] Immigrant/Refugee
- [ ] In Home Supports Needed
- [ ] Incompetent to Proceed (ITP)
- [ ] Intellectual/Developmental Disability
- [ ] Language Barrier
- [ ] Law Violations
- [ ] LGBTQ
- [ ] Lockout/Abandonment
- [ ] Medical/Health Issue
- [ ] Parental Engagement
- [ ] Parental Issue
- [ ] Physical Disability
- [ ] Placement Disruption
- [ ] Pregnancy
- [ ] Residential Placement
- [ ] Runaway
- [ ] School Discipline
- [ ] Self-Harm
- [ ] Sexually Problematic Behavior
- [ ] Special Education (504 and/or IEP)
- [ ] Substance Abuse
- [ ] Transportation
- [ ] Trauma
- [ ] Truancy
- [ ] Youth Age
- [ ] Youth Engagement
- [ ] Other (please specify)

* 21. What is the **primary reason** for holding this staffing team for this youth? (Choose One)

- ◯ Severe Mental Health Issues
- ◯ Behavior Issues
- ◯ Sexual Behavior Issues
- ◯ Developmental Issues
- ◯ Substance Abuse Issues
- ◯ Post-Adoption Issues

* 22. Is this an abandonment/lockout case?

- ◯ Yes
- ◯ No

## Interagency Meeting and Case Report Form 2018

* 23. Was the case diverted?

- ◯ Yes
- ◯ No

## Interagency Meeting and Case Report Form 2018

* 24. What system challenges were involved in this Youth's case? (Select all that apply)

- [ ] Funding Not Available
- [ ] Protocol Inconsistency
- [ ] Services Not Available
- [ ] Placement
- [ ] Cost Sharing
- [ ] Other (please specify)
- [ ] Transition (independent living)
- [ ] Transition (out of or into another system)
- [ ] Cross County/Circuit
- [ ] Multi-agency Cooperation
- [ ] Improper Services/Supports



## Case Outcome

**NOTE:**
A case is **resolved** when the review team is able to find a viable solution to the case's challenges.

A case is considered **referred** when it requires elevated or de-escalated to another review team. For example, a local review team is requesting assistance from the regional review team.

A case is considered **pending** when it is ongoing and there is no need to refer the case elsewhere, however all issues have not yet been resolved. It is assumed that the review team will staff the case again until resolution or referral.

* 25. What is the outcome of the review team case staffing?

26. When was the case **resolved or referred**? (Please leave blank if the case is pending.)

Date

MM/DD/YYYY

27. What services were/will be provided to clients to resolve case challenges? (examples: In home supports provided by APD; Specialized medical foster home placement, Out of state DJJ residential placement, DCF CAT Team engaged along with DJJ transition services, etc.)

* 28. Which agencies (including providers and sub-contractors) provided financial support to resolve case challenges? (Select all that apply.)

- [ ] Agency for Health Care Administration
- [ ] Agency for Persons with Disabilities
- [ ] Department of Children and Families
- [ ] Department of Health
- [ ] Department of Juvenile Justice
- [ ] Education
- [ ] Guardian ad Litem Program
- [ ] Florida's Office of Early Learning
- [ ] Managing Entity
- [ ] Other (please specify)

29. Please provide additional information pertinent to the statewide report about this case below.

Interagency Meeting and Case Report Form
2018

* 30. If your team did not staff any individual cases, what was discussed?

- [ ] **Our team <u>did</u> staff individual cases**
- [ ] Coordination between agencies
- [ ] Identification and review of placement/service needs for children
- [ ] Review of resource capacity of local systems of care
- [ ] Review of local policies, procedures, working relationships and practice culture
- [ ] Identification of opportunities to improve interagency coordination
- [ ] Involvement of contracted providers in the problem resolution process
- [ ] Review of specific children in an effort to resolve any placement disputes when staff is not able to reach resolution
- [ ] Resource provider presentation
- [ ] Cross training opportunity
- [ ] Other (please specify)

## Interagency Meeting and Case Report Form 2018

31. If your team **did not** staff a case, can you provide a meeting date?

Meeting Date

MM/DD/YYYY

## Interagency Meeting and Case Report Form 2018

### State Review Team Follow Up

**Please take the opportunity to communicate with the State Review Team.**

32. Please share any best practices, recommendations, requests and/or comments that you would like to share with the State Review Team.