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| *Systems*  *of care*  *for schools & community partners* | Early identification  •  individualized intervention |
| **Youth (& families) who may be at risk for future mental health or delinquency concerns are the intended recipients of this service.** **There are no income guidelines and there is no charge to families.****Eligibility** **Children and youth ages 0-21** may participate. They must have an identified need in **at least one** of the following domains: Basic needs, Social supports, Emotional needs, Educational needs, Community supports, Housing, Health, or Safety.  Identification of youth with a need will take place at the school or community level and be referred on to SOC Coordinator for services, after obtaining verbal or signed consent from parent or guardian. Coordinator will then initiate contact with youth & family to assess potential needs. This is intended to be an ***informal, short-term intervention*** which can lead to referrals to other services. | Empowering FamiliesThrough connection with community resources and a variety of family services. **Whitney Nordvold** CACS SOC Program Coordinator (605)280-1328  **Emmalee Krekelberg** CACS  SOC Program Coordinator  (605)280-3247 |
| *Systems*  *of care*  *a partnership of*  *Families, schools,*  *& community behavioral health* | Early identification  •  individualized intervention |
| **Referral Info Needed:**  **Youth Name:**  **Parent/Guardian Name(s):**  **Best contact number:**  **Youth date of birth:**  **Youth last 4 #s of soc sec #:**  **County of residence:**  **School attending & Grade:**  **Ethnicity:**  **# of children in home:**  **Please return to Whitney Nordvold and Emmalee Krekelberg at CACS:** [Whitney.Nordvold@cacsnet.org](mailto:Whitney.Nordvold@cacsnet.org)  **(605)295-2138**  **I, the parent or legal guardian of above named youth, consent to services which may include: educational groups and social skills groups, mental health or behavioral screenings and services as identified by family partnering with CACS clinical specialists. I consent to having (identify one or more entities such as PSD, Boys & Girls Club, Teen Court)**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **communicate with SOC coordinator regarding my child.**  **Signed\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\*Parent may indicate a verbal consent over the phone, and document signed by referral source, if requested by parent.**  **This consent will expire one year from today or when otherwise revoked.** | This service is fully funded and there is never a charge to families.  **What are the needs of the youth &/or family (priority)?**  **Health needs**  **Basic Needs (food, clothing, shelter)**  **Safety needs**  **Social supports**  **Emotional / Behavioral**  **Community involvement/connections**  **Housing needs**  **Educational needs** |