York County Human Services

CASSP Child & Adolescent Service System Programming

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(717) 771-9095

SUBMIT FORM

Child Name: DOB: MA Number (if applicable)

Home address: Contact number:

School District: Grade: Building:

Mental Health Diagnosis (if known): IQ: above 70 below 70 unknown

Parent/Guardian Information:

Name: Relationship: Contact information:

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Primary language of parent/guardian: Primary language of student:

Is a translator able to be provided by school/organization? YES NO

Meeting availability:

Reason for referral (choose at least one):

- School Attendance
- Educational Placement
- Behavior School
- Behavior Home
- Non-compliant
- Medical Issues
- Service Coordination
- More Services Needed
- Services Ineffective
- Team Planning
- Other:

Is mental health case management involved? YES NO

Agency (if known):

Does student have a current IEP? YES NO

Please describe the behaviors or concerns which lead to making this CASSP referral:

Please list current services, if known:

What do you hope to accomplish through this CASSP meeting:

Person making referral: Organization: Contact number:

Committed to the belief that family has the potential to energize hope, guide change, and foster healing