

## CSA Referral Form for School Division Private Day and Residential Placements

**Referral Source:**     York County School Division     Poquoson City Public Schools

**Date of Referral:**

**Placement Start Date:**

**Case Manager:**  
**Email:**

**Telephone Number:**

Name of Child	DOB	Sex	Social Security Number	Race
<b>Parent/Legal Guardian</b> *Note relationship to child if not biological parent.				
<b>Address</b>			<b>Telephone</b>	

Current School	Grade	Special Education Eligibility Classification	Student Testing Identifier

**Does the child have a DSM-IV Mental Health Diagnosis?**     Yes     No  
If yes, please list diagnoses:

**Does the child have a diagnosis of Autism, Asperger's, or Pervasive Developmental Disorder?**     Yes     No  
If yes, please specify:

**Does the child take medication prescribed for a mental health disorder?**     Yes     No  
If yes, please list:

**Is the child enrolled in Medicaid and eligible to receive Medicaid services?**     Yes     No

**Is the child placed in a Medicaid Certified Facility?**     Yes     No

**Is the child currently placed in an out of state facility?**     Yes     No  
If yes, please specify name and location:

**Has the child ever been placed out of the public school?**     No, skip to next section  
 Yes, check all that apply and include dates of placement:

<input type="checkbox"/> Private Day Placement *Name: *Dates:	<input type="checkbox"/> Juvenile Detention/Corrections Facility *Name: *Dates:
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<input type="checkbox"/>	Residential Treatment Center *Name: *Dates	<input type="checkbox"/>	Crossroads *Name: *Dates:
<input type="checkbox"/>	Psychiatric Facility *Name: *Dates:	<input type="checkbox"/>	Post Dispositional Program (DJJ) *Name: *Dates:

**Presenting Problem(s)/Reason for Referral**

<input type="checkbox"/>	Developmental disability	<input type="checkbox"/>	Serious emotional disturbance	<input type="checkbox"/>	Delinquency/Court involvement
<input type="checkbox"/>	Traumatic brain injury	<input type="checkbox"/>	ADHD	<input type="checkbox"/>	Sexual abuse (perpetrator)
<input type="checkbox"/>	Physical disability/chronic health problem	<input type="checkbox"/>	IEP/School related issues	<input type="checkbox"/>	Aggressive behavior <input type="checkbox"/> Verbal <input type="checkbox"/> Physical
<input type="checkbox"/>	Autism	<input type="checkbox"/>	Disruptive behavior	<input type="checkbox"/>	Intellectual Disability
Other (please specify):					

- Detail the specific circumstances leading to this referral.

**Date of CANS:**

**What are the primary needs of the child, based on the CANS?**

- 1)
- 2)
- 3)
- 4)

**What are the centerpiece strengths of the child, based on the CANS? \*May also include additional strengths not listed on CANS**

- 1)
- 2)
- 3)
- 4)

**What placement(s) are you requesting?**

Service Type	Provider	# of Units	Type of Unit	Rate per Unit	Total Cost	Dates of Service
Private Day Placement						
Private Day Placement						

**Please describe what is needed to step down this child to a less restrictive educational setting.**

**The following is attached to this referral:**

- Signed FAPT consent from the parent/legal guardian
- Signed copy of the IEP indicating need for Private Day/Residential placement
- Signed IEP addendum for changes in placement
- Completed CANS

\_\_\_\_\_  
Case Manager

\_\_\_\_\_  
Date