

Data required for the CMH Referral Summary Form

- The IEP Assessment Report forms (Assessment Report pages 1-3) are generated within the IEP Triennial Review upon locking the Assessment Plan. If conducting a supplemental assessment, the report is currently included in with the Supplemental Plan. An Additional Assessment Report can be added to the Supplemental IEP Review. This process will allow you to lock the Supplemental Assessment Plan and include the report with the Supplemental IEP.

The assessment report should address the specific requirements for the referral for AB 2726 services. Information may be copied/pasted from existing assessment reports or newly written into the current assessment report. These required elements include:

- Background information regarding the need for the referral:
Describe the student's educational history, including social/emotional issues evident in the school setting. As appropriate, include additional information about the child's medical history, psychiatric hospitalizations, medications, and/or treatment.
- Summary of emotional or behavioral characteristics:
Describe how the student's emotional or behavioral problems impede his or her ability to benefit from educational services. Indicate how significant the characteristics are by their rate of occurrence and intensity. As appropriate, describe the current emotional concerns evident by specific student behaviors. For example:
 - has assaulted peers on campus when teased three times during the past month
 - usually responds using one word answers to questions or interactions initiated by both peers and adults on a daily basis, which limits interaction in the classroom
 - has expressed thoughts of harming himself or others to a counselor and a teacher
- A description of the school counseling, psychological and guidance services, and/or other interventions, including the results of those interventions that have been provided to the student, including the initiation, duration, and frequency of services:
Describe the interventions previously utilized to address the student's social/emotional needs and the student's response, or lack thereof, to the interventions. Include specific information regarding who provided the service, when, and for how long. If the IEP team determines that such interventions are clearly inappropriate, document which of these services were considered and why they were determined to be inappropriate. Include the student's response to behavior interventions such as a Behavior Support Plan (BSP), or a Behavior Intervention Plan (BIP) based on a functional analysis assessment (FAA). Also include interventions utilized with the student by other agencies, such as Probation or Child Protective Services if appropriate.
- As determined by educational assessments, the pupil's functioning, including cognitive functioning, is:
Indicate that the student has cognitive functioning at a level sufficient to enable the pupil to benefit from mental health services. Include documentation such as psychoeducational assessment completed by school staff and/or documentation of the student's response to previous counseling efforts, together with contact information for the provider of the counseling services.
- The IEP team concurs that the student has behavioral or emotional characteristics associated with a condition that cannot be described solely as a social maladjustment or temporary adjustment problem, and cannot be resolved in less than three months of school counseling.
- Additional comments:
Include any other information that may be pertinent to assist the CMH evaluator in making a determination of the appropriate educationally related mental health services for the student.

IEP Documentation of Referral to CMH

Convene the IEP Team Meeting.

- Document the decision to refer in the IEP team action:

| Topic | Explanation | Action | Responsible for Follow-up |
|--|---|------------------------------|---|
| <input type="checkbox"/> 1. Reconvene | | Date _____ Time _____ | |
| <input type="checkbox"/> 2. Additional Assessments | | Location _____ | |
| <input checked="" type="checkbox"/> 3. Referral(s) to agencies | Referral to CMH for evaluation of need for mental health services | Complete CMH Referral Packet | (name), School Psychologist (name), Case Manager |
| <input type="checkbox"/> 4. Additional item(s) <i>(please specify)</i> : | | | |

- Complete the referral packet and all supporting documentation. Provide the completed packet to the district's AB 2726 coordinator **no later than four (4) days** from the date of the IEP team's decision to refer the student, via AB 2726, to CMH.

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CMH contacts the parent to obtain permission to assess and assigns an assessor. The district's AB 2726 coordinator is notified of the assessor and contacts the case manager to provide the name of the assessor. Upon receipt of this information, the case manager must:

- Generate a Supplemental IEP Review meeting event in Encore.
- Contact the assessor regarding the Supplemental IEP Review team meeting.
- Invite parent and required district personnel to the meeting (administrator or designee, general education teacher, special education teacher, school psychologist, parent and CMH assessor)
- Ensure that the meeting is held within 60 days of the date the parent signs the CMH assessment plan.

Documentation of Services on the IEP

If CMH services are added to the IEP--

Document the need on Present Levels of Educational Performance:

SOCIAL/EMOTIONAL/BEHAVIOR SKILLS

NOT AN AREA RELATED TO SUSPECTED DISABILITY

PRESENT LEVELS OF PERFORMANCE:

Present levels are...

AREAS OF NEED:

- Is an area of need*
- Is not an area of need

CMH recommends...

Document the services on IEP page 1:

| | | | | | | | |
|--|--|--|--|--|------------------------------|------------------------|---|
| AGENCY INFORMATION | | | | | | | |
| <input type="checkbox"/> DEPT OF REHABILITATION | <input type="checkbox"/> CA CHILD SERVICES (CCS) | <input checked="" type="checkbox"/> COUNTY MENTAL HEALTH | <input type="checkbox"/> REGIONAL CENTER | <input type="checkbox"/> DEPT OF SOCIAL SERVICES | | | |
| | | <input checked="" type="checkbox"/> ELIGIBLE | <input checked="" type="checkbox"/> RECEIVING SERVICES | | | | |
| PRIMARY DISABILITY Emotional Disturbance (ED) | | | | | | | |
| OTHER PROGRAM INFORMATION | | | | | | | |
| EXTENDED SCHOOL YEAR: | | <input type="checkbox"/> YES | <input checked="" type="checkbox"/> NO | ESY PLACEMENT: | | | |
| TRANSPORTATION: | | <input type="checkbox"/> YES | <input checked="" type="checkbox"/> NO | REASON: | | | |
| PARTICIPATING IN WORKABILITY: | | <input type="checkbox"/> YES | <input type="checkbox"/> NO | | | | |
| PHYSICAL EDUCATION: General PE | | | | | | | |
| GENERAL EDUCATION PARTICIPATION PERCENTAGE | | | | | | | |
| OUTSIDE GENERAL CLASSROOM FOR SPECIAL EDUCATION SERVICES (K-12) 2.78 % | | | | INSIDE GENERAL CLASSROOM (K-12) 97.22 % | | | |
| THIS PERCENTAGE IS BASED ON A DISTRICT WIDE AVERAGE OF INSTRUCTIONAL MINUTES FOR GRADES K-12, WHICH MEETS OR EXCEEDS THE STATE REQUIREMENT FOR INSTRUCTIONAL MINUTES PER DAY FOR 180 SCHOOL DAYS (EXCLUDING EXTENDED SCHOOL YEAR). | | | | | | | |
| <input type="checkbox"/> THIS STUDENT DOES NOT ATTEND SCHOOL THE TYPICAL NUMBER OF HOURS - ATTENDS SCHOOL _____ HOURS/WEEK. | | | | | | | |
| PRESCHOOL SETTING (ages 3-5 including kindergarten) | | | | | | | |
| SPECIAL EDUCATION SERVICES * | | | | | | | |
| SERVICE | CODE | START DATE | END DATE | NUMBER OF NO. | HOURS/ MINUTES PER HRS./MIN. | WEEK/ MONTH/YEAR FREQ. | ENVIRONMENT MAJORITY OF TIME (SELECT ONE) |
| Resource Specialist | 2600 | 04/20/2007 | 04/19/2008 | 5 | Hours | Week | Gen Ed |
| <input type="checkbox"/> SUBSEQUENT PRIMARY SERVICE: (If appropriate - use only when changing a primary service prior to the date ending this IEP.) | | | | | | | |
| CMH/Outpatient Services | 5490 | 06/10/2007 | 12/01/2007 | 50 | Minutes | Week | Outside Gen Ed |
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NOTE:

Open and save ALL pages of the Supplemental IEP Review prior to checking compliance and locking the event.

Complete the tasks upon locking the IEP:

In the IEP Component and Component Detail

IEP COMPONENT SAVE CANCEL

*Service: CMH/Outpatient Services (Duplicated)

*Provider Type #1: County Mental Health

Provider Type #2:

Provider Type #3:

Anticipated End:

Env. Code:

SessionID: 1

IEP COMPONENT

Service: CMH/Outpatient Services (Duplicated) Env. Code:

Anticipated End:

IEP COMPONENT DETAIL SAVE CANCEL

*Scheduled Start: 09/22/2005

Actual Start:

Actual End:

Delay Reason:

*Svc. School: Balboa Elementary--0013A

Sessions: 1 Per: Week

*Provider: County Mental Health [SHOW PROVIDERS FILTERED BY SERVICING SCHOOL](#)

Indirect Sessions: Per:

*Clone Reason: Original Implementation

Direct Duration: 50

Direct Time unit: Minutes

Indirect Duration:

Indirect Time Unit: