

MENTAL HEALTH CLINICIAN

Interview Questions & Performance Evaluation Factors

Performance Evaluation Factors	Related Interview Questions
Provide crisis intervention services.	<ul style="list-style-type: none"> ▪ What is your understanding of the CAC model and the services provided at our center? ▪ What experience do you have working with children and adults impacted by abuse and trauma? ▪ Discuss how you would respond to a family presenting in crisis. ▪ Tell us about your knowledge of community resources or community programs.
Conducts psychosocial and/or trauma-specific assessments.	<ul style="list-style-type: none"> ▪ What experience do you have conducting psychosocial assessments? ▪ What general types of assessment tools have you used or for which you have received training in order to administer, score, and interpret data? ▪ What types evidence-based and/or trauma-specific assessments have you used?
Assess client functioning and develop individualized treatment plan within 30 days that is periodically re-assessed.	<ul style="list-style-type: none"> ▪ What developmental stage/age client is your favorite to work with and why? ▪ Least favorite and why? ▪ What is your process for developing a treatment plan and what do you consider the most important elements to include?

Performance Evaluation Factors	Related Interview Questions
<p>Provide individual, group, and family therapy to clientele at the center and at satellite locations.</p>	<ul style="list-style-type: none"> ▪ Tell us about your general theoretical approach to counseling. ▪ What are your experiences with individual (child and adult), group, and family counseling? Please consider ages, special circumstances, etc. ▪ Discuss any specialized training, such as TF-CBT, that you have received and how you have applied it in counseling sessions. ▪ Tell us about the counseling session you consider to be your best session and why.
<p>Maintain case files including session case notes, treatment plans, monthly progress reports, telephone consultations, and termination summaries.</p>	<ul style="list-style-type: none"> ▪ What tools and strategies do you use to stay organized? ▪ What is/would be your preferred system of maintaining case notes, completing timely documentation and tracking service data?
<p>Provide testimony of fact for the county criminal and civil courts that pertain to the center's Mental Health Services cases.</p>	<ul style="list-style-type: none"> ▪ What is your knowledge base and level of familiarity with the judicial process as it relates to child abuse investigation and prosecution? ▪ What experience do you have in providing court testimony? ▪ On a scale of 1 to 10, how would you rank yourself in terms of public speaking and why? ▪ Give some examples of your public speaking experiences.

Performance Evaluation Factors	Related Interview Questions
Provide diagnosis and billing information monthly on all cases seen.	<ul style="list-style-type: none"> ▪ What is your experience with DSM diagnosis of children? Adults? ▪ What is your experience with insurance billing? ▪ Are you currently active on any insurance provider rosters, including Medicaid?
Collect data and submit client mental health statistics to Clinical Director and/or Supervisor.	<ul style="list-style-type: none"> ▪ What types of mental health data have you previously tracked? ▪ What methods did you use to track data and for what purposes?
Prepare and present cases for clinical review.	<ul style="list-style-type: none"> ▪ Tell us about the process you would go through to prepare for a clinical case review, including what types of information you would include. ▪ What are your professional experiences with preparing and presenting cases for clinical review?
Coordinate with the Clinical Director or Supervisor on all cases needing psychiatric/psychological consultation.	CAC cases needing psychiatric or psychological consultation are coordinated with Clinical Directors or Supervisors. Under what circumstances would you consider a client in need of psychiatric or psychological consultation?
Comply with the Mental Health Services Policies and Procedures manual.	
Assist Clinical Director or Supervisor in preparing monthly Mental Health Services report.	Explain your systems for tracking mental health services and data regarding missed appointments, rescheduled, etc.

Performance Evaluation Factors	Related Interview Questions
Participate in scheduled case staffings and those held on an as-needed basis.	
Collaborate with and provide consultation to Child Protective Services, Police Department, District Attorney's Office, and other social service agencies and mental health professionals directly involved with Mental Health Services cases.	<ul style="list-style-type: none"> ▪ Tell us about your experience participating as a member of a group initiative/project or multi-disciplinary team. ▪ What were some of the strengths and challenges you encountered as a team member? ▪ Tell us about your experience in working with law enforcement, prosecution, and Child Protective Services. What benefits and challenges do you foresee in working with each of these partner agencies? ▪ Describe your communication style. ▪ Provide an example of how you effectively resolved a conflict in a prior job. ▪ Tell me about a time when you had to work closely with a co-worker whom you disliked or with whom you had trouble working. What did you do to make the relationship work? ▪ What type of person do you find the most frustrating to work with?
Conduct on-going communication with Center Child Advocates and Volunteer Coordinator.	When working within a busy team environment, what are some strategies you would use to ensure ongoing communication occurs while maintaining professional boundaries and confidentiality?

Performance Evaluation Factors	Related Interview Questions
Maintain good standing with the appropriate State licensing board and professional group membership affiliations.	What professional membership organizations are you a current member of?
Adhere to confidentiality policy.	How would you adhere to confidentiality policies while working within a multidisciplinary team environment?
Displays desirable personal qualities, including tact, good judgment, flexibility, positive attitude, high professional standards and ethics, and an ability to get along with a variety of people from various disciplines.	<p>What are some self-care practices that you would or currently engage in to prevent secondary trauma?</p> <p>Tell us about stressors you have encountered in prior jobs and how you dealt with them?</p> <p>How do you feel about dealing with sexual abuse issues most of the time?</p>
Participate in regular peer review in which clinical proficiency may be reviewed.	How comfortable are you receiving feedback from your peers and your supervisor regarding your job performance?
Maintain cross-cultural awareness in the performance of all responsibilities.	Describe your experience counseling diverse populations.
Participate in applicable/appropriate/related professional development opportunities.	

MENTAL HEALTH CLINICIAN

REPORTS TO: {SUPERVISOR}

COMPENSATION: {SALARY}

EXEMPT STATUS: {SALARIED VS HOURLY}, {EXEMPT VS. NON-EXEMPT}

COMMITMENT TYPE: {FULL-TIME VS. PART-TIME}, {ON-GOING, TEMPORARY}

BASE OF OPERATIONS: {CITY, STATE}

SUMMARY:

Provide assessment, diagnosis, and treatment services to children and adults impacted by abuse and trauma.

ESSENTIAL FUNCTIONS:

- Provide crisis intervention services.
- Conduct psychosocial and/or trauma-specific assessments
- Assess client functioning and develop individualized treatment plan within 30 days that is periodically re-assessed.
- Provide individual, group, and family therapy to clientele at the center and at satellite locations.
- Maintain case files including session case notes, treatment plans, monthly progress reports, telephone consultations, and termination summaries.
- Provide testimony of fact for the county criminal and civil courts that pertain to the center's Mental Health Services cases.
- Provide diagnosis and billing information monthly on all cases seen.
- Collect data and submit client mental health statistics to Clinical Director and/or Supervisor.
- Prepare and present cases for clinical review.
- Coordinate with Clinical Director or Supervisor on all cases needing psychiatric/psychological consultation.
- Comply with the Mental Health Services Policies and Procedures Manual.
- Assist Clinical Director or Supervisor in preparing monthly Mental Health Services report.
- Participate in scheduled case staffings and those held on an as-needed basis.
- Collaborate with and provide consultation to Child Protective Services (CPS), Police Department, District Attorney's Office, and other social service agencies and mental health professionals directly involved with Mental Health Services cases.
- Conduct on-going communication with Center Child Advocates and Volunteer Coordinator.

- Maintain good standing with the appropriate State licensing board and group membership affiliations.
- Participate in regular peer review in which clinical proficiency may be reviewed.
- Participate in applicable, appropriate, related professional development opportunities.
- Adhere to confidentiality policy.
- Maintain cross-cultural awareness in the performance of all responsibilities.
- All other responsibilities and duties as from time to time designated by the Agency or added to the scope of responsibility for this position.

JOB REQUIREMENTS AND QUALIFICATIONS:

- **Education:**
 - Master’s Degree in mental health-related field; or
 - Registered student in a formal graduate program in a mental health-related field.
- **Training (licenses and certifications):**
 - A professional license to practice independently as a Licensed Professional Counselor, Licensed Marriage and Family Therapist, Licensed Psychologist, Licensed Master/Clinical Social Worker; or
 - A requirement to attend supervision with a licensed mental health professional on a consistent basis, and
 - A training plan requiring 10 contact hours of specialized, trauma-focused mental health training, clinical consultation, clinical supervision, peer supervision, and/or mentoring within the first 6 months of association, or
 - Demonstrated relevant experience prior to association.
- **Experience:**
 - Prior relevant experience as practicing mental health professional working with abused children.
 - Specialized clinical knowledge and advanced clinical skill in the areas of assessment, diagnosis, and treatment of mental, emotional, and behavioral disorders.
 - Experience with court testimony preferred.
 - Prior work with CPS, law enforcement agencies, and district attorneys’ offices preferred.
- **Knowledge Requirements:**
 - Knowledge of trauma focused, evidence based therapy.
 - Basic computer skills.

- Proficiency with Microsoft Windows XP and 7 Operating Systems, Word, Excel, and Outlook.

- **Intellectual and Physical Requirements:**

- Read, write, and speak English fluently.
- Bi-lingual (English/Spanish) preferred.
- Bending, stooping, reaching and other movement required in dealing with children. Lifting of office materials (up to 20 lbs).

OTHER INFORMATION:

- Travel may occasionally be required for educational or business purposes. It is not anticipated that any travel would last more than 2 – 3 days.
- Desirable personal qualities include: tact, good judgment, flexibility, a positive attitude, high professional standards and ethics, and an ability to get along with a variety of people from various disciplines.
- Employment dependent upon the successful completion of a background check, including criminal and CPS clearances.

Name of CAC

Mental Health Treatment Referral Form to Name of Mental Health Treatment Provider (MHTP)

Date of Referral: _____

Name of Child: _____ Date of Birth: _____ Gender: _____

Legal Guardian(s): _____

Relation to Child: _____ Phone Number: _____

Address: _____

Is there a Divorce Decree or other Court Order in place affecting the child? *(If yes, please attach.)*

Yes No

With whom does the child live? List all household members.

Date of Intake at CAC: _____ Type of Alleged Abuse: _____

Alleged Perpetrator's Relationship to Child: _____

CPS Contact: _____ Phone Number: _____

Law Enforcement Contact: _____ Phone Number: _____

Additional Information:

Other than the child listed above, who is being referred for mental health treatment? (Attach additional sheets if necessary.)

Name: _____ Relationship to Child: _____

Legal Guardian (if under 18): _____ Phone Number: _____

Name: _____ Relationship to Child: _____

Legal Guardian (if under 18): _____ Phone Number: _____

Name: _____ Relationship to Child: _____

Legal Guardian (if under 18): _____ Phone Number: _____

Attachments:

Two-way authorization for information sharing between **Name of CAC** and **Name of MHTP**.

Authorization for **Name of MHTP** to share information with the **Name of CAC** MDT.

(NOTE: In the event that the client/guardian does not provide authorization for **Name of MHTP to disclose information to the MDT, the CAC agrees to maintain the confidentiality of all information disclosed by **Name of MHTP** in accordance with applicable state and federal law, and will only release information when required or permitted by law.)**

Copy of Current Court Order / Divorce Decree (if applicable)

Other: _____

Name of CAC staff completing this form: _____

Title: _____ Phone Number: _____

Referral Authorized By: **Name of CAC Executive Director**

Signature: _____ Date: _____

PROFESSIONAL SERVICES AGREEMENT BETWEEN
[NAME OF CAC]
and
[NAME OF MENTAL HEALTH TREATMENT PROVIDER]

This AGREEMENT is entered into by and between [NAME OF CAC], hereinafter referred to as CAC, and [NAME OF PROVIDER], hereinafter referred to as MENTAL HEALTH TREATMENT PROVIDER (MHTP), for the purposes of providing consultation and/or specialized trauma-focused mental health treatment services to the clients of the CAC.

A. DEFINITIONS

1. **Case Review** is a formal process in which the multidisciplinary team meets on a routine basis to discuss the investigation of current child abuse cases and enable members to provide status updates and any new information pertinent to those cases. It is also a venue to discuss the services needed by the child and family in order to ensure their safety and wellbeing.
2. **Client** refers to a child who receives services through the CAC as part of an investigation into alleged sexual and/or physical abuse and/or neglect and/or when the child is a witness to violence. Client also refers to the child's non-offending caregiver/family member(s).
3. **Crime Victims Compensation (CVC)** is the program administered by the Texas Office of the Attorney General and dedicated to providing victims of violent crime financial assistance for crime-related expenses that cannot be reimbursed by insurance or other sources.
4. **Multidisciplinary Team (MDT)** refers to representatives of the entities involved in the investigation and prosecution of child abuse cases. These entities include Child Protective Services (CPS), law enforcement departments, district and county attorneys' offices, medical and mental health professionals, and CAC staff (i.e., forensic interviewer, family advocate and other staff as determined by the CAC). The MDT members work collaboratively to reduce trauma to the child and non-offending caregiver/family members and ensure the most effective coordinated response and plan of action.
5. **Trauma-focused Mental Health Services** refer to interventions that directly address the traumatic event in session or interventions found to directly reduce the likelihood of a child re-experiencing a traumatic event. These services take into account the relationship between traumatic experiences and the client's current functioning, and place priority on the client's safety, choice and control, and resilience and recovery. Therapeutic interventions are empirically supported, include trauma assessment, and focus on reducing the long-term adverse impacts of trauma and the risk of future abuse.

B. MENTAL HEALTH TREATMENT SERVICES TO BE PROVIDED

As part of the multidisciplinary team response, and in an effort to ensure healing and recovery for traumatized children, MHTP will provide mental health treatment services designed to meet the unique needs of the children and their non-offending caregivers/family members (clients) referred for services by the CAC. These services will be made available and provided according to the terms and conditions set forth in this Agreement.

1. MHTP will provide specialized trauma-focused mental health services to clients referred by the CAC. These services may include:
 - a. Crisis intervention services.
 - b. Trauma-specific assessment, including a full trauma history (which, at a minimum, should address abuse history).
 - c. Use of standardized measures (assessment tools) initially and periodically thereafter to measure treatment progress.
 - d. Non-offending caregiver/family member engagement.
 - e. An individualized treatment plan that is periodically re-assessed.
 - f. An individualized evidence-informed treatment appropriate for the client.
 - g. Referral to other community services as needed.
 - h. Referral to a secondary level of care or psychiatrist as needed.

2. MHTP will also provide services to the referred client’s non-offending caregivers/family members, including screening, assessment and mental health treatment that takes into consideration the range of mental health issues that could impact the client’s recovery or safety. Services must be customized to:
 - a. Address the emotional impact of the abuse allegations and issues triggered by the allegations.
 - b. Reduce or eliminate the risk of future abuse.
 - c. Provide an opportunity for non-offending siblings and other children in the household to discuss their own reactions and experiences triggered by the allegations.
 - d. Address family issues within a confidential therapeutic relationship.

MHTP will assess the client’s non-offending caregiver’s mental health, substance abuse, domestic violence, and other trauma history and make referrals for treatment, as appropriate.

3. MHTP shall provide to the CAC monthly progress updates for clients referred by the CAC, including attendance data.

C. SERVICE DELIVERY LOCATION

Provider agrees to provide direct mental health services to the referred clients and their non-offending caregivers/family members at the following location(s):

Physical Address:	Mailing Address:	Phone Number:
1.		
2.		

D. MHTP ACKNOWLEDGEMENTS & RESPONSIBILITIES

1. MHTP is an independent contractor and CAC assumes no responsibility for actions by MHTP. MHTP agrees to hold CAC harmless from all liabilities arising from MHTP's services or failure to perform same. Nothing in this Agreement is intended to, or shall be construed to create a partnership, agency, joint venture, employment or similar relationship.
2. MHTP will not be entitled to any of the benefits that CAC may make available to its employees, including, but not limited to, group health or life insurance, or retirement benefits.
3. MHTP is solely responsible for, and will file on a timely basis, all tax returns and payments required to be filed with, or made to, any federal, state or local tax authority with respect to the performance of services and receipt of fees under this Agreement.
4. MHTP shall execute a written Informed Consent for Mental Health Services with the client and/or legal guardian that includes information on the therapy to be provided, contact information for the MHTP and client, and the limits of confidentiality and access of shared information regarding the client and client status. MHTP will provide a copy of the signed Informed Consent to the CAC.
5. MHTP shall maintain good standing with the appropriate state licensing board.
6. MHTP shall maintain professional liability occurrence insurance in the amount of \$1,000,000 each Incident or each Occurrence and \$3,000,000 in the aggregate.
7. MHTP shall create and maintain accurate and adequate clinical and financial records in accordance with the Texas Administrative Code and other applicable state and federal law. MHTP will protect the confidentiality of clients' written and electronic records and other sensitive information, and ensure the records are stored in a secure location not accessible by unauthorized personnel. MHTP will maintain and dispose of records in a manner that protects clients' confidentiality and is in compliance with applicable laws and professional standards.
8. MHTP shall ensure that all faxed and/or electronic communication between MHTP and CAC will be transmitted securely and in accordance with all Health Insurance Portability and Accountability Act (HIPAA) and state law requirements.
9. MHTP shall provide to the CAC authorized representative progress updates on each CAC client receiving services, in accordance with the format in Attachment 1 of this Agreement. These updates will be due to the CAC on the 10th day of each month and will cover the previous month's activities.
10. MHTP shall serve as a formal partner on the CAC's multidisciplinary team and will execute:
 - a. The Memorandum of Understanding that addresses the team's assurance to coordinating the investigation and prosecution of child abuse cases in a manner that emphasizes the best interests of the children. The MOU also addresses the team's

commitment to providing advocacy and recovery services for child victims and their non-offending family members.

- b. The Working Protocols, which detail the coordinated team process in working child abuse cases. The protocols include procedures for each step of the coordinated process, including the roles and responsibilities of team members and procedures for case reviews.
11. MHTP shall participate in regularly scheduled Case Review Meetings as part of the multidisciplinary team to ensure that referred clients' mental health and treatment needs can be assessed and taken into consideration as the team makes decisions regarding the clients' cases. MHTP will also serve as an expert resource and provide input in determining if a child/non-offending caregiver needs to be referred for mental health services.
 12. Prior to the start date of Agreement, MHTP will provide to the CAC the following:
 - a. Current Résumé and/or Curriculum Vitae.
 - b. IRS Form W-9, Request for Taxpayer Identification Number (TIN) and Certification.
 - c. Copy of current, active mental health provider Professional License.
 - d. Copy of current, active Certificate of Professional Liability Insurance in accordance with Section D.6 of this agreement.
 - e. Proof of provider good standing (current print out from licensing board website).
 - f. Completed and signed form to enable CAC to conduct a background check.
 13. MHTP will participate in periodic clinical supervision or consultation with a licensed mental health professional.

E. CAC RESPONSIBILITIES

1. Within the first two weeks after the start date of the contract, CAC shall provide MHTP an orientation that includes a review of the following:
 - a. Texas Standards for Children's Advocacy Centers (Texas Family Code, Chapter 264, Subchapter E). In addition, CAC will provide MHTP a copy of the full Texas CAC Standards on Mental Health, Case Review and the Multidisciplinary Team.
 - b. Written procedures for administering CAC mental health programming, including processes for making client referrals, data collection and progress updates.
 - c. CAC mission and services.
 - d. Case Review process, including schedule of meetings and expectations for participation.
2. Prior to referring clients to MHTP, CAC will execute the following with the client and/or legal guardian:
 - a. A two-way Authorization to Release Confidential Information that will enable the exchange of client information from the MHTP to the CAC. CAC will include a copy of the Authorization with the written Referral when referring a client to MHTP. The CAC will utilize the formats included in Attachments 2 and 3 of this Agreement.

- b. An Authorization to Release Confidential Information that will enable the MHTP to provide the necessary disclosure of information to the Multidisciplinary Team that will assist in the investigation or the provision of additional services to the client. CAC will include a copy of the Authorization with the written Referral when referring a client to MHTP. The CAC will utilize the format included as Attachment 4 of this Agreement.
3. CAC will inform MHTP of dates, times, and locations of Case Review Meetings and multidisciplinary team training opportunities.
4. CAC may provide MHTP opportunities for additional training or consulting related to the services to be provided under this Agreement.

F. BILLING AND MHTP REMUNERATION

1. MHTP agrees to a billable hourly rate of \$[COST] per session, not to exceed [NUMBER] sessions per client and/or non-offending caregivers/family members without written approval from CAC.
2. MHTP agrees to a billable rate of \$[COST] to provide courtroom testimony in child abuse cases that involve CAC-referred clients.
3. All billing and payment collection for services rendered to insured clients is the full responsibility of MHTP. MHTP agrees to accept, as applicable, payment from private insurance, Medicaid, and/or the Crime Victims Compensation Fund.
4. In such instances of CAC direct payment of invoiced services to MHTP, no part of MHTP's compensation will be subject to withholding by the CAC for the payment of any social security, federal, state or any other employee payroll taxes. The CAC will regularly report amounts paid to MHTP by filing Form 1099 MISC with the Internal Revenue Service as required by law.
5. MHTP is solely responsible for and must maintain adequate records of expenses incurred in the course of performing services under this Agreement.

G. GENERAL PROVISIONS

1. **Period of Agreement:** This Agreement effective date shall be [START DATE] and shall terminate on [END DATE], unless otherwise specified in written amendment. CAC retains the right to extend this Agreement for one-year increments contingent upon MHTP meeting the obligations contained herein.
2. **Termination:** This Agreement may be terminated upon 30 days written notice by either party or at any time upon mutual agreement of the parties. During the 30-day termination period and to the extent practicable, both parties will discuss and agree upon a plan to ensure a smooth transition for clients currently in treatment, including proper termination of the client/therapist relationship.
3. **Modification of Agreement:** Any additions, modifications, or deletions to the terms of this Agreement shall be made by amendment in writing and signed by the authorized representatives of both parties. Below is the contact information for the authorized

representatives to whom requests for modification must be made:

CAC Authorized Representative:

[NAME]
[TITLE]
[ADDRESS]
[ADDRESS]
[PHONE NUMBER]
[EMAIL ADDRESS]

MHTP Authorized Representative:

[NAME]
[TITLE]
[ADDRESS]
[ADDRESS]
[PHONE NUMBER]
[EMAIL ADDRESS]

4. **Dispute Resolution:** In the event of any dispute arising out of or relating to this Agreement, the parties shall attempt, in good faith, to promptly resolve the dispute mutually between them. If the dispute cannot be resolved by mutual agreement, nothing herein shall preclude either party's right to pursue remedy or relief by civil litigation, pursuant to the laws of the State of Texas. The prevailing party in any litigation between the parties arising from this Agreement shall be entitled to recover reasonable attorneys' or in-house counsel's fees.

H. EXECUTION OF AGREEMENT:

IN WITNESS WHEREOF, the parties have executed this Agreement on the dates accompanying the signatures below.

[NAME], [TITLE]
[ORGANIZATION]

Date

[NAME], [TITLE]
[NAME OF CAC]

Date

Attachment 1 – Monthly Summary to CAC
Monthly Summary for Name of CAC Clients

Mental Health Treatment Provider: _____

Monthly Summary for (Month/Year): _____

Name of Client: _____

Evidence-based Treatment Used: _____

Was Fidelity Checklist Used? Yes No

Summary of Treatment Sessions:

Date of Session	Focus of Session (Component of Model)	Caregiver Participation (At least 15 minutes)	
		Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Yes <input type="checkbox"/>	No <input type="checkbox"/>

Treatment Plan Goals Addressed During Reporting Period:

Treatment Goal	Progress (see key below)	Concerns/Barriers

Key:

- Insufficient
- Satisfactory
- Complete
- N/A

Attachment 1 – Monthly Summary to CAC

Summary of Session Attendance for Reporting Period:

# Sessions Completed	# Cancelled Sessions	# No-shows

Name of MHTP

Date

Name of MHTP practice (if applicable)

Attachment 2 – Mental Health Treatment Referral Form

Name of CAC

Mental Health Treatment Referral Form to

Name of Mental Health Treatment Provider (MHTP)

Date of Referral: _____

Name of Child: _____ Date of Birth: _____ Gender: _____

Legal Guardian(s): _____

Relation to Child: _____ Phone Number: _____

Address: _____

Is there a Divorce Decree or other Court Order in place affecting the child? *(If yes, please attach.)*

Yes No

With whom does the child live? List all household members.

Date of Intake at CAC: _____ Type of Alleged Abuse: _____

Alleged Perpetrator's Relationship to Child: _____

CPS Contact: _____ Phone Number: _____

Law Enforcement Contact: _____ Phone Number: _____

Additional Information:

Attachment 2 – Mental Health Treatment Referral Form

Other than the child listed above, who is being referred for mental health treatment? (Attach additional sheets if necessary.)

Name: _____ Relationship to Child: _____

Legal Guardian (if under 18): _____ Phone Number: _____

Name: _____ Relationship to Child: _____

Legal Guardian (if under 18): _____ Phone Number: _____

Name: _____ Relationship to Child: _____

Legal Guardian (if under 18): _____ Phone Number: _____

Attachments:

Two-way authorization for information sharing between **Name of CAC** and **Name of MHTP**.

Authorization for **Name of MHTP** to share information with the **Name of CAC** MDT.

(NOTE: In the event that the client/guardian does not provide authorization for **Name of MHTP to disclose information to the MDT, the CAC agrees to maintain the confidentiality of all information disclosed by **Name of MHTP** in accordance with applicable state and federal law, and will only release information when required or permitted by law.)**

Copy of Current Court Order / Divorce Decree (if applicable)

Other: _____

Name of CAC staff completing this form: _____

Title: _____ Phone Number: _____

Referral Authorized By: **Name of CAC Executive Director**

Signature: _____ Date: _____

Attachment 3 – Authorization to Share Confidential Information with CAC

**Authorization to Share
Confidential Mental Health Information/
Protected Health Information between
Name of MHTP and Name of CAC**

Name of CAC contracts with Name of MHTP to provide specialized, evidence-based mental health services to eligible clients who receive services through Name of CAC. By signing this authorization, you agree to allow Name of MHTP and Name of CAC to share information with each other about your child's participation in mental health services for the purposes of coordinating service delivery.

Print Client's Name _____ Date of Birth _____ Social Security Number _____
Date(s) of service (if known): _____

PART One – Authorization for Release of Information to Name of CAC by Name of MHTP

I hereby authorize Name of MHTP to disclose the individually identifiable health information as described below, which may include psychotherapy notes, to Name of CAC.

By accepting the records pursuant to this Authorization, the recipient(s) acknowledges that the protected health information covered by this release is confidential, privileged and protected by federal and state privacy statutes and regulations, and agrees that Name of MHTP's release of the individually identifiable health information will continue to be protected by federal and state privacy statutes and regulations.

Description of information to be released: (check all that apply.)

- All confidential mental health information/protected health information**
- Information regarding participation in treatment/dates of sessions
- Assessment/diagnosis information
- Treatment planning information
- Progress/prognosis information
- Discharge information
- Psychotherapy notes
- Other: _____

Description of the purpose of the use and/or disclosure:

Attachment 3 – Authorization to Share Confidential Information with CAC

PART TWO – Authorization for Release of Information to **Name of MHTP by **Name of CAC****

I hereby authorize **Name of CAC** to disclose information related to my child’s case to **Name of MHTP** for the purposes of coordinating mental health service delivery. I understand that this authorization is voluntary and that I may refuse to sign this authorization.

By accepting the records pursuant to this Authorization, the recipient(s) acknowledges that the protected health information covered by this release is confidential, privileged and protected by federal and state privacy statutes and regulations, and agrees that **Name of CAC**’s release of the individually identifiable health information will continue to be protected by federal and state privacy statutes and regulations.

Signature of Client or Client’s Representative

Date

Printed Name of Client or Client’s Representative

Relationship to Client or Legal Authority (attach supporting documentation.)

Attachment 4 – Authorization to Share Confidential Information with MDT

**Authorization for Release of
Confidential Mental Health Information/
Protected Health Information to MDT by
Name of Mental Health Treatment Provider (MHTP)**

Name of CAC contracts with Name of MHTP to provide specialized, evidence-based mental health services to eligible clients who receive services through Name of CAC. As part of the contract, Name of MHTP also participates in Case Review with Name of CAC and its multidisciplinary team (MDT) for the purposes of joint investigation and case coordination. By signing this authorization, you agree to allow Name of MHTP to disclose information to the MDT about your child's participation in mental health services.

I hereby authorize Name of MHTP to disclose the individually identifiable health information as described below, which may include psychotherapy notes. I understand that this authorization is voluntary and that I may refuse to sign this authorization. I further understand that my health care and the payment for my health care will not be affected if I do not sign this form. I understand that even if I do not sign this form, Name of MHTP may still be authorized to release records regarding treatment of me/my child to medical and law enforcement personnel under federal and state law.

By accepting the records pursuant to this Authorization, the recipient(s) acknowledges that the protected health information covered by this release is confidential, privileged and protected by federal and state privacy statutes and regulations, and agrees that Name of MHTP's release of the individually identifiable health information will continue to be protected by federal and state privacy statutes and regulations.

Print Client's Name	Date of Birth	Social Security Number
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Date(s) of service (if known): _____

Description of information to be released: (check all that apply.)

- All confidential mental health information/protected health information**
- Information regarding participation in treatment/dates of sessions
- Assessment/diagnosis information
- Treatment planning information
- Progress/prognosis information
- Discharge information
- Psychotherapy notes
- Other: _____

Description of the purpose of the use and/or disclosure:

Attachment 4 – Authorization to Share Confidential Information with MDT

The individually identifiable health information described herein shall be released to:

- All County MDT members**
- The Texas Department of Family and Protective Services
- Name of Partner Agency
- Name of Partner Agency
- Name of Partner Agency
- Name of Partner Agency

I intend for this Authorization to remain in full force and effect until I revoke it in writing. Further, it is my intent that a copy of this Authorization shall have the same effect as the original.

I further understand that I may revoke this authorization at any time by notifying Name of MHTP in writing at Address of MHTP. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Signature of Client or Client’s Representative

Date

Printed Name of Client or Client’s Representative

Relationship to Client or Legal Authority (attach supporting documentation.)

Name of CAC

Mental Health Treatment Referral Form to Name of Mental Health Treatment Provider (MHTP)

Date of Referral: _____

Name of Child: _____ Date of Birth: _____ Gender: _____

Legal Guardian(s): _____

Relation to Child: _____ Phone Number: _____

Address: _____

Is there a Divorce Decree or other Court Order in place affecting the child? *(If yes, please attach.)*

Yes No

With whom does the child live? List all household members.

Date of Intake at CAC: _____ Type of Alleged Abuse: _____

Alleged Perpetrator's Relationship to Child: _____

CPS Contact: _____ Phone Number: _____

Law Enforcement Contact: _____ Phone Number: _____

Additional Information:

Other than the child listed above, who is being referred for mental health treatment? (Attach additional sheets if necessary.)

Name: _____ Relationship to Child: _____

Legal Guardian (if under 18): _____ Phone Number: _____

Name: _____ Relationship to Child: _____

Legal Guardian (if under 18): _____ Phone Number: _____

Name: _____ Relationship to Child: _____

Legal Guardian (if under 18): _____ Phone Number: _____

Attachments:

Two-way authorization for information sharing between **Name of CAC** and **Name of MHTP**.

Authorization for **Name of MHTP** to share information with the **Name of CAC** MDT.

(NOTE: In the event that the client/guardian does not provide authorization for **Name of MHTP to disclose information to the MDT, the CAC agrees to maintain the confidentiality of all information disclosed by **Name of MHTP** in accordance with applicable state and federal law, and will only release information when required or permitted by law.)**

Copy of Current Court Order / Divorce Decree (if applicable)

Other: _____

Name of CAC staff completing this form: _____

Title: _____ Phone Number: _____

Referral Authorized By: **Name of CAC Executive Director**

Signature: _____ Date: _____