



WASHINGTON COUNTY OREGON

CONSENT FOR ISA SCREENING AND SERVICES

I understand that my child (Name: _____) has been referred to Washington County Department of Health and Human Services, Mental Health (WCMH) to determine if he/she is eligible for the Intensive Service Array (ISA). I also understand that a screening called the Child Adolescent Service Intensity Instrument (CASII) needs to be conducted to determine if my child meets the criteria to receive these services. The CASII screening involves reviewing available background documents including my child's mental health, medical, alcohol and drug records. The screening process may also require review of records from DHS Child Welfare, Juvenile Justice, and/or Oregon Youth Authority if these agencies are involved with my child. I understand that information used for the CASII screening and the results of that screening will be kept confidential unless I sign an Authorization to Disclose Information Form or as otherwise allowed by law.

I understand that if my child is eligible for the ISA, a Care Coordinator will be assigned to my family from the Washington County Child and Family Care Coordination team. The Care Coordinator will assist my family in identifying goals and obtaining mental health services for my child. I hereby authorize a Washington County Care Coordinator to provide all services and activities necessary for care coordination activities.

I know that I can refuse to sign this authorization and that I can withdraw my consent at anytime but that actions already taken before I have withdrawn my consent cannot be revoked. I understand that participation in the CASII screening is voluntary and hereby give my consent for my child to participate in the CASII screening.

Client Signature

Date

Witness Signature

Date

Interpreter Signature (if applicable)

Date