My
Family Care Organizer

If found, please return this CONFIDENTIAL Family Care Organizer to:

Ramsey County Children's Mental Health Collaborative (RCCMHC). family@rccmhc.org 800-565-2575

Or Contact: _____

*version 06-2023

Table of Contents

RCCMHC

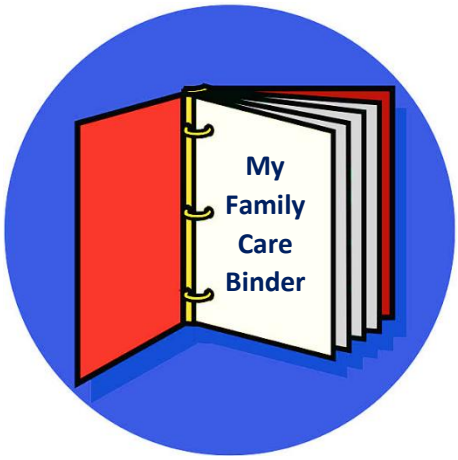
Ramsey County Children's Mental Health Collaborative

This Family Care Binder was prepared for you by RCCMHC. Ideas for the contents of this Binder came from local families and providers. If you have suggestions for how we can improve, please let us know!

*RCCMHC provides FREE connections to therapy and resources, care team coordination, resilience coaching, coping skills practice, trainings, and help filling out your Care Organizer!

Email: family@rccmhc.org Call/Text 800-565-2575 Website: https://www.rccmhc.org/

Your Family Care Binder



Do you have too many appointments and details to juggle? Are you lost under a mountain of paperwork? A Family Care Binder will make it easier to organize paperwork, keep track of changes, and share information with mental health professionals, doctors, school staff, childcare, and extended family members etc.

- Track daily care, notes and meetings
- List important contact names and numbers
- Maintain health records and diagnoses
- Keep crisis and emergency plans

Inside Your Care Binder….

- ☐ 3-ring binder with divider tabs
- ☐ Sheet protectors to store special papers
- ☐ Hole puncher
- ☐ Folder with 3 holes in the side
- ☐ Plastic pages to store business cards
- ☐ Pouch for pen, pencil and highlighter
- ☐ Blank forms, worksheets, and lined paper
- ☐ Your paperwork

IDEA: Put a page into a plastic sheet protector. Use a dry erase marker to write on the page. Erase and re-use. Try this for forms like the Weekly Meal Planner!

How is this Family Care Binder organized?

This Family Care Binder has 8 sections with pre-printed section tab dividers. It also comes with pre-printed forms and information sheets.

1. Contacts
2. Calendar & Notes
3. Medical
4. School
5. Mental Health
6. Our Family
7. Home Management
8. Wellbeing

How to assemble your Care Binder Care

Step 1: Quick look
First, take a look at the whole binder without stopping to fill in any pages. Ask yourself: How will these worksheets and info pages help me to manage my child's mental health?

Step 2: Personalize it
This is YOUR care binder. Decorate your binder. Doodle on the pages. Use our cover page or create your own! You will use your Care Binder more often if you enjoy looking at it. Keep pages that are useful and ***throw away pages you don't need.*** If you need extra copies of pages, you can download the binder here: https://www.rccmhc.org/all-in-one-place

Step 2: Fill out the forms
The best way to fill out long boring forms is with a "buddy." Work with your child's doctor, nurse, social worker, case manager, or teacher. Ask a faith leader or friend to help. Or, get together with other parents who have Care Binders and work on your forms as a group activity! Plan to fill out a few forms at a time and don't forget to take breaks!

Step 4: Gather your paperwork
Each section has a suggested list of "other documents" that you might want to add to your Care Binder (diagnostic assessments, school handbook, or emergency room visit summary…)

→ **What is MOST important?**
You don't need to add everything to your Care Binder! Instead, ask yourself: What items would make my life easier? What paperwork do I look for the most? What information is needed by my child's service providers or my child's other caregivers? Keep all of your other paperwork in a file drawer or box where you can find it if needed.

How to use your Family Care Binder

Bring your care binder to all medical appointments, IEP and school meetings, mental health appointments, emergency room visits, hospital stays, vacations, etc.

- Store your binder where it is easy to find. This helps you if you need to grab it quickly. It also helps anyone else who needs to find information when you are not available.
- Brag about your binder ☺ Share your binder with your child's primary care doctor, case manager, therapists, school nurse, teachers, daycare staff, family members, and others caring for your child. Ask them to help you fill your binder.
- Use the information in your binder to advocate for your child and family.
- Update your binder often!

If you need help with your Care Binder, **call or text our Family Peer Specialists 800-565-2575**

Contacts

Emergency Contacts

Hospital (Mental Health): _____
Name: _____
Address: _____
Phone: _____
E-mail: _____

Other Hospital: _____
Name: _____
Address: _____
Phone: _____
E-mail: _____

Emergency Contact: _____
Name: _____
Address: _____
Phone: _____
E-mail: _____

Emergency Contact: _____
Name: _____
Address: _____
Phone: _____
E-mail: _____

Children's Crisis Response (651) 266-7878

Licensed mental health professionals are available 24 hours a day, 7 days a week. They will talk with you over the phone or meet with you at home or in the community. NOTE: This service works best if you can call before the situation becomes an emergency. If possible, call when you notice that things are starting to get challenging and you need extra support.

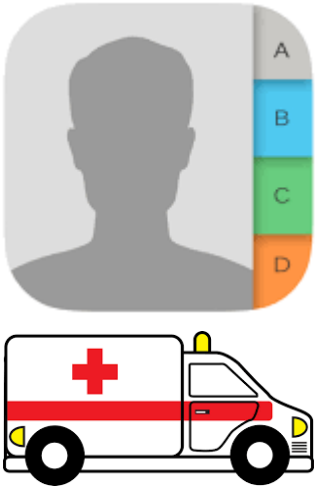
Urgent Care for Adult Mental Health (651) 266-7900

402 University Ave. E., St. Paul - Walk-ins Welcome
Monday - Friday 8:00 a.m. to 5:30 p.m.

If your child is a danger to self or others, DIAL 911.

If there is physical danger, if your child needs to be restrained, or if you think your child will not cooperate with hospitalization, it is time to call 911

National Suicide Prevention Lifeline 1-800-273-TALK (8255)



Inpatient Hospitalization

https://www.rccmhc.org/inpatient-hospitalization

Accepting children under the age of 12 AND adolescents

Abbott NW Hospital
800 E. 28th St.; Minneapolis, MN 55407

Fairview Riverside- University of Minnesota Medical Center Fairview 2450 Riverside Ave; Minneapolis, MN 55454

Prairie Care
12915 63rd Ave N; Maple Grove, MN 55369

Accepting ONLY Adolescents (12-18)

Children's Hospitals and Clinics of MN
333 North Smith Ave; St. Paul, MN 55102

(06-2023 update) The unit is currently caring for adolescent patients but will expand to admit younger patients in the months ahead.

Medical Providers & Pharmacy

My Child's Name _____

Primary Care (Family Doctor or Pediatrician)
Name: _____
Address: _____
Phone: _____
E-mail: _____

Dentist
Name: _____
Address: _____
Phone: _____
E-mail: _____

Pharmacy
Name: _____
Address: _____
Phone: _____
E-mail: _____

Specialist: _____
Name: _____
Address: _____
Phone: _____
E-mail: _____

Specialist: _____
Name: _____
Address: _____
Phone: _____
E-mail: _____

Specialist: _____
Name: _____
Address: _____
Phone: _____
E-mail: _____

Does your child have a...

Dermatologist? **Orthodontist?** **Optometrist?** **Physical Therapist?**

Mental Health Providers

My Child's Name _____

Case Manager
Name: _____
Address: _____
Phone: _____
E-mail: _____

Psychiatrist
Name: _____
Address: _____
Phone: _____
E-mail: _____

Therapist
Name: _____
Address: _____
Phone: _____
E-mail: _____

Specialist: _____
Name: _____
Address: _____
Phone: _____
E-mail: _____

Specialist: _____
Name: _____
Address: _____
Phone: _____
E-mail: _____

Does your child have a...

Case Manager? **Family Therapist?** **Skills worker?**

School Contacts

My Child's Name _____

School- Main Office
Name: _____
Address: _____
Phone: _____
E-mail: _____

Teacher
Name: _____
Address: _____
Phone: _____
E-mail: _____

School Nurse
Name: _____
Address: _____
Phone: _____
E-mail: _____

Special Education Director/504 Coordinator
Name: _____
Address: _____
Phone: _____
E-mail: _____

Specialist: _____
Name: _____
Address: _____
Phone: _____
E-mail: _____

Specialist: _____
Name: _____
Address: _____
Phone: _____
E-mail: _____

Does your child have a...

Speech Pathologist? **Occupational Therapist?** **School Aide?**

Community Services

My Child's Name _____

Babysitter/Respite Provider
Name: _____
Address: _____
Phone: _____
E-mail: _____

Child Care: _____
Name: _____
Address: _____
Phone: _____
E-mail: _____

Specialist: _____
Name: _____
Address: _____
Phone: _____
E-mail: _____

Specialist: _____
Name: _____
Address: _____
Phone: _____
E-mail: _____

Specialist: _____
Name: _____
Address: _____
Phone: _____
E-mail: _____

The Center for Inclusive Child Care (CICC) provides relationship-based coaches to work with early child care/ education professionals and parents to successfully include children with unique needs or challenging behaviors in order to prevent expulsion. 651.641.8339 https://www.inclusivechildcare.org/

Does your child have a...

After School Program? Coach? Probation Officer? Transportation Provider?

Nutritional/Holistic Health/ Healers

My Child's Name _____

Specialist: _____
Name: _____
Address: _____
Phone: _____
E-mail: _____

Specialist: _____
Name: _____
Address: _____
Phone: _____
E-mail: _____

Specialist: _____
Name: _____
Address: _____
Phone: _____
E-mail: _____

Specialist: _____
Name: _____
Address: _____
Phone: _____
E-mail: _____

Does your child have a...

Chiropractor? **Acupuncturist?** **Nutritionist?** **Spiritual Counselor?**

Support Network (For You & Your Child)

Use this page as a reminder that you are not alone. List people who are trustworthy, reliable, nonjudgmental etc. Remember that you might contact different people in different situations. The person that you call when you need to have a good cry may not be the same person that you call when you need child care or help filling out paperwork…

Name: _____
Address: _____
Phone: _____
E-mail: _____

Name: _____
Address: _____
Phone: _____
E-mail: _____

Name: _____
Address: _____
Phone: _____
E-mail: _____

Name: _____
Address: _____
Phone: _____
E-mail: _____

Who can you or your child turn to for support?

A Faith Group Leader? Family or Friend? A Local Agency Support? A Respite Provider? A Parenting Group Member? A Parent Support 1-800 Number or Texting Line?

IDEA: Use a "Support Network" App?

MY3 is a FREE app on Google Play and Apple App Store. It was designed to help people quickly reach out to their support network during times of stress and sadness. The app helps you create a support system, build a safety plan, customize coping strategies, create your own resource page, and access the National Suicide Prevention Hotline 24/7.

Family Care Team

	Name	
	Job Title	
	Email	
	Phone	
	Tasks	
	Name	
	Job Title	
	Email	
	Phone	
	Tasks	
	Name	
	Job Title	
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	Email	
	Phone	
	Tasks	

Calendar & Note

Appointments

Bring this Care Binder with you to your next appointment to help you remember the questions you want to ask. If you know that the appointment will be stressful, consider bringing someone with you to help take notes. Or, ask if you can use your cell phone to record the discussion. Then, you can listen to the recording later and remember what was said.

Date	Time	Doctor/Provider	Child	Questions	Answers

QUESTIONS TO ASK: Test Results ● School Forms ● Prescriptions ● Next Appointment ● Concerns ● Family Needs ● Symptoms ● Referrals ● Care Plan ● Side Effects ● Insurance ● Other Dr.'s Reports

IDEA: The AHRQ Question Builder App helps patients prepare for medical visits so they get the most from their appointments. Users can choose or customize questions they want to ask at their appointment.

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Phone Call Notes

Date and Time	Person/ Agency	Phone Number	Child	Notes

Phone Call Notes

Date and Time	Person/ Agency	Phone Number	Child	Notes

Phone Call Notes

Date and Time	Person/ Agency	Phone Number	Child	Notes

Phone Call Notes

Date and Time	Person/ Agency	Phone Number	Child	Notes

Remember to *BREATHE*. Drink some water. Stretch and move. Hug somebody. Laugh.

You can do it!

My To-Do List
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My To-Do List
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My To-Do List
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◄ December

January 2023

February ►

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

NOTES:

◄ January

February 2023

March ►

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12	13	14	15	16	17	18
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26	27	28				

NOTES:

March 2023

◄ February | April ►

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NOTES:

◄ March

April 2023

May ►

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30						

NOTES:

◄ April

May 2023

June ►

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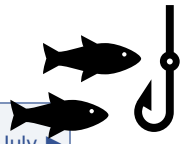

June 2023

◄ May | July ►

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18	19	20	21	22	23	24
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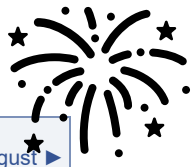

◄ June

July 2023

August ►

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9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

NOTES:

◄ July

August 2023

September ►

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13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

NOTES:

◄ August

September 2023

Octobe

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24	25	26	27	28	29	30

NOTES:

◄ September

October 2023

November ►

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

NOTES:

◄ October

November 2023

December ►

Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

NOTES:

◄ November

December 2023

January ►

Sun	Mon	Tue	Wed	Thu	Fri	Sat
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

NOTES:

Medical

Other Documents That I Could Add to This Section:

- ☐ Diagnostic Assessments
- ☐ Lab Results
- ☐ Written Instructions after Discharge from Hospital or ER
- ☐ Consent/Permission for Medical Treatment form
- ☐
- ☐

Medical Insurance & Managed Health Care

Place a copy of your card(s) in your binder OR fill out the information below.

State of Minnesota- Managed Health Care
Member Help Desk: 651-431-2670 or 800-657-3739

Case Worker and Contact Info _____

Program Name (Ex. MinnesotaCare, Medical Assistance/ MA) _____

Member # _____

Member Name _____

Birthdate _____

Rx BIN _____

SAMPLE CARD


Minnesota Health Care Programs
Present this card every time you go for medical care.
Member Number 1234567890
Member Name JANE A DOE
Birth Date 11/15/2005
Gender FEMALE
Rx BIN 610459
More information on back of card.

Name of Health Plan (Ex. Blue Plus, Health Partners, UCare) _____

Health Plan ID _____

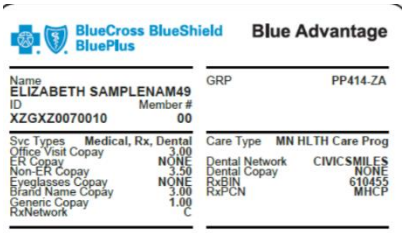
Member # _____

Group #_____

Dental Network _____

Customer Service Phone # _____

SAMPLE CARD


BlueCross BlueShield BluePlus
Blue Advantage
Name ELIZABETH SAMPLENAM49
ID XZGXZ0070010
Member # 00
GRP PP414-ZA
Svc Types Medical, Rx, Dental
Office Visit Copay 3.00
ER Copay NONE
Non-ER Copay 3.50
Eyeglasses Copay NONE
Brand Name Copay 3.00
Generic Copay 1.00
RxNetwork C
Care Type MN HLTH Care Prog
Dental Network CIVICSMILES
Dental Copay NONE
RxBIN 610455
RxPCN MHCP

Primary Medical Insurance (If Not Public Aid)

Member Name _____

Health Plan ID _____

Group # _____

Service Type _____

Rx BIN _____

Care Type _____

Customer Service Phone # _____

Medical Insurance & Managed Health Care

Place a copy of your card(s) in your binder OR fill out the information below.

Secondary Medical Insurance (If Not Public Aid)

Member Name _____

Health Plan ID _____

Group # _____

Service Type _____

Rx BIN _____

Care Type _____

Customer Service Phone # _____

Dental Insurance (If Not Public Aid)

Member Name _____

Health Plan ID _____

Group # _____

Service Type _____

Rx BIN _____

Care Type _____

Customer Service Phone # _____

Vision Insurance (If Not Public Aid)

Member Name _____

Health Plan ID _____

Group # _____

Service Type _____

Rx BIN _____

Care Type _____

Customer Service Phone # _____

Medical History- Tracking and Sharing

Here are a few ideas for tracking and sharing your child's medical history.

Your Care Binder

Fill out the medical charts in this section of your Care Binder. Then, share with anyone who needs medical information. Since these are paper forms, you will have to make sure they are up to date. And, of course… you have to remember to bring your Binder!

Emergency Information Form (EIF)

Ask your doctor/provider to fill out and sign the Emergency Information Form for Children with Special Health Care Needs. (We include the form in your Care Binder.)

- Share a copy with other members of your child's support team.
- During a crisis, give your completed form to Ambulance/EMS, Police, or Emergency Room
- Interactive and Printable Forms are available online here: https://www.acep.org/by-medical-focus/pediatrics/medical-forms/emergency-information-form-for-children-with-special-health-care-needs/#sm.00017q9m7o176eezu3m1v8zguubnh

  "The American College of Emergency Physicians and the American Academy of Pediatrics are pleased to present the Emergency Information Form (EIF). This important document will assure prompt and appropriate care for Children with Special Health Care Needs (CSHCN). Now, when these patients present to emergency departments or health care professionals with an acute illness or injury, physicians, parents, EMS professionals, and nurses will be able to use the EIF as a tool to transfer critical information. The EIF will ensure that a child's complicated medical history is concisely summarized and available when it is needed most - when the child presents with an acute health problem at a time when neither parent nor pediatrician is immediately available. AAP and ACEP believe the EIF is an important tool that will help facilitate the transfer of relevant information for Children with Special Health Care Needs."

Minnesota Standard Consent Form to Release Health Information (ROI)

If you want doctors or service providers to be able to share information with each other, you need to fill out a Release of Information(ROI) form. Doctors, hospitals, therapists, and schools etc. will all have similar forms that you can use. Unfortunately, they do not always accept each other's ROI forms. This standard form was developed by the Minnesota Department of Health. The form must be accepted by a Minnesota provider as a legally enforceable request under the Minnesota Health Records Act.

- Psychotherapy Notes that are kept by your child's psychiatrist, psychologist or other mental health professional are kept in a separate filing system in their office and not with your other health information. So, if you are requesting the release of psychotherapy notes, you have to use a new blank form and only check that category. You must also

name the professional who will release the psychotherapy notes. (We included 2 Forms in your Care Binder.)

Ask your providers to give you copies of the ROI forms that you have already signed. Hole punch them and keep them in this section of your Binder so you can monitor who has what information about your child(ren). This can also help you determine who else needs a release so they can collaborate on your child's care.

Paper Forms--- Stored Online

If you are worried that you might forget to bring your Care Binder, you could fill out and then save the pages from this binder to a secure cloud-based storage or an e-health tool. Some people also choose to take photos of important pages and stored them on their phone.

Online Parent Portals

Some medical systems have an online Parent Portal. These are helpful because the information is up-to-date and can be viewed by the doctor and the parent. Unfortunately, when your child is seen by several providers and systems, you may end up with several online Parent Portals. And, different providers/ medical systems are not always able to share information between portals.

Emergency Information Form for Children With Special Needs

Last name:

American College of Emergency Physicians®

American Academy of Pediatrics

Date form completed	Revised	Initials
By Whom	Revised	Initials

Name: **Birth date:** **Nickname:**

Home Address: **Home/Work Phone:**

Parent/Guardian: **Emergency Contact Names & Relationship:**

Signature/Consent*:

Primary Language: **Phone Number(s):**

Physicians:

Primary care physician: **Emergency Phone:**

Fax:

Current Specialty physician: **Emergency Phone:**

Specialty: **Fax:**

Current Specialty physician: **Emergency Phone:**

Specialty: **Fax:**

Anticipated Primary ED: **Pharmacy:**

Anticipated Tertiary Care Center:

Diagnoses/Past Procedures/Physical Exam:

1.

2.

3.

4.

Synopsis:

Baseline physical findings:

Baseline vital signs:

Baseline neurological status:

*Consent for release of this form to health care providers

Last name:

Diagnoses/Past Procedures/Physical Exam continued:

Medications:	Significant baseline ancillary findings (lab, x-ray, ECG):
1.	
2.	
3.	
4.	Prostheses/Appliances/Advanced Technology Devices:
5.	
6.	

Management Data:

Allergies: Medications/Foods to be avoided	and why:
1.	
2.	
3.	
Procedures to be avoided	**and why:**
1.	
2.	
3.	

Immunizations (mm/yy)

Dates						Dates					
DPT						Hep B					
OPV						Varicella					
MMR						TB status					
HIB						Other					

Antibiotic prophylaxis: Indication: Medication and dose:

Common Presenting Problems/Findings With Specific Suggested Managements

Problem	Suggested Diagnostic Studies	Treatment Considerations

Comments on child, family, or other specific medical issues:

Physician/Provider Signature: **Print Name:**

Instructions for Minnesota Standard Consent Form to Release Health Information

Important: Please read all instructions and information before completing and signing the form.

An incomplete form might not be accepted. Please follow the directions carefully. If you have any questions about the release of your health information or this form, please contact the organization you will list in section 3.

This standard form was developed by the Minnesota Department of Health as required by the Minnesota Health Records Act of 2007, Minnesota Statutes, section 144.292, subdivision 8. The form must be accepted by a Minnesota provider as a legally enforceable request under the Minnesota Health Records Act. If completed properly, this form must be accepted by the health care organization(s), specific health care facility(ies), or specific professional(s) identified in section 3.

A fee may be charged for the release of the health information.

The following are instructions for each section. Please type or print as clearly and completely as possible.

1 Include your full and complete name. If you have a suffix after your last name (Sr., Jr., III), please provide it in the "last name" blank with your last name. If you used a previous name(s), please include that information. If you know your medical record or patient identification number, please include that information. All these items are used to identify your health information and to make certain that only your information is sent.

2 If there are questions about how this form was filled out, this section gives the organization that will provide the health information permission to speak to the person listed in this section. **Completing this section is optional.**

3 In this section, state who is sending your health information. **Please be as specific as possible.** If you want to limit what is sent, you can name a specific facility, for example Main Street Clinic. Or name a specific professional, for example chiropractor John Jones. Please use the specific lines. Providing location information may help make your request more clear. Please print "All my health care providers" in this section if you want health information from all of your health care providers to be released.

4 Indicate where you would like the requested health information sent. It is best to provide a complete mailing address as not everyone will fax health information. A place has been provided to indicate a deadline for providing the health information. **Providing a date is optional.**

5 Indicate what health information you want sent. If you want to limit the health information that is sent to a particular date(s) or year(s), indicate that on the line provided.

For your protection, it is recommended that you initial instead of check the requested categories of health information.

This helps prevent others from changing your form.

EXAMPLE: jh All health information

If you select **all health information**, this will include any information about you related to mental health evaluation and treatment, concerns about drug and/or alcohol use, HIV/AIDS testing and treatment, sexually transmitted diseases and genetic information.

Important: There are certain types of health information that require special consent by law.

Chemical dependency program information comes from a program or provider that specifically assesses and treats alcohol or drug addictions and receives federal funding. This type of health information is different from notes about a conversation with your physician or therapist about alcohol or drug use. To have this type of health information sent, mark or initial on the line at the bottom of page 1.

Psychotherapy notes are kept by your psychiatrist, psychologist or other mental health professional in a separate filing system in their office and not with your other health information. **For the release of psychotherapy notes, you must complete a separate form noting only that category. You must also name the professional who will release the psychotherapy notes in section 3.**

6 Health information includes both written and oral information. If you do not want to give permission for persons in section 3 to talk with persons in section 4 about your health information, you need to indicate that in this section.

7 Please indicate the reason for releasing the health information. If you indicate marketing, please contact the organization in section 4 to determine if payment or compensation is involved. If payment or compensation to the organization is involved, indicate the amount.

8 This consent will expire one year from the date of your signature, unless you indicate a different date or event. Examples of an event are: "60 days after I leave the hospital," or "once the health information is sent."

9 Please sign and date this form. If you are a legally authorized representative of the patient, please sign, date and indicate your relationship to the patient. You may be asked to provide documents showing that you are the patient or the patient's legally authorized representative.

MINNESOTA MDH DEPARTMENT of HEALTH

This form was approved by the Commissioner of the Minnesota Department of Health on January 30, 2008 and updated in August 2015.

THE GREAT SEAL OF THE STATE OF MINNESOTA L'ETOILE DU NORD 1858

AUGUST2015

Minnesota Standard Consent Form to Release Health Information

1 Patient information

First name _____ Middle name _____ Last name _____

Patient date of birth ___ / ___ / _____ Previous name(s) _____
MM DD YYYY

Home address _____

City _____ State _____ Zip code _____

Daytime phone _____ E-mail address (optional) _____

Medical Record/patient ID number (optional) _____

2 Contact for information about how this form was filled out (optional):

I give permission for the organization(s) listed in section 3 permission to talk to

First name _____ Last name _____ about how this form was completed,

this person can be reached at: Daytime phone _____ E-mail address (optional) _____

3 I am requesting health information be released from at least one of the following:

Organization(s) name _____

Specific health care facility or location(s) _____

Specific health care professional's name(s) _____

4 I am requesting that health information be sent to:

Organization(s) name _____

And/or person: First name _____ Last name _____

Mailing address _____

City _____ State _____ Zip code _____

Phone (optional) _____ Fax (optional) _____

Information needed by (date) ___ / ___ / _____ (optional)
MM DD YYYY

5 Information to be released

IMPORTANT: indicate only the information that you are authorizing to be released.

☐ Specific dates/years of treatment _____

☐ All health information *(see description in instructions for what is included)*

OR to only release specific portions of your health information, indicate the categories to be released:

☐ History/Physical	☐ Mental health	☐ HIV/AIDS testing
☐ Laboratory report	☐ Discharge summary	☐ Radiology report
☐ Emergency room report	☐ Progress notes	☐ Radiology image(s)
☐ Surgical report	☐ Care plan	☐ Photographs, video, digital or other images
☐ Medications	☐ Immunizations	☐ Billing records

☐ Other information or instructions _____

The following information requires special consent by law. Even if you indicate **all health information,** you must specifically request the following information in order for it to be released:

☐ Chemical dependency program *(see definition in instructions)*

☐ Psychotherapy notes *(this consent cannot be combined with any other; see instructions)*

Minnesota Standard Consent Form to Release Health Information

Patient's name _____

6 Health information includes written and oral information

By indicating any of the categories in section 5, you are giving permission for written information to be released **and** for a person in section 3 to talk to a person in section 4 about your health information.

If you do not want to give your permission for a person in section 3 to talk to a person in section 4 about your health information, indicate that here (check mark or initials) _____

7 Reason(s) for releasing information

- ☐ Patient's request
- ☐ Review patient's current care
- ☐ Treatment/continued care
- ☐ Payment
- ☐ Insurance application
- ☐ Legal
- ☐ Appeal denial of Social Security Disability income or benefits
- ☐ Marketing purposes (payment or compensation involved? ☐ NO ☐ YES, amount_____)
- ☐ Sale (payment or compensation to entity maintaining the information? ☐ NO ☐ YES)
- ☐ Other (please explain) _____

8

I understand that by signing this form, I am requesting that the health information specified in Section 5 be sent to the third party named in section 4.

I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in section 3.

If the organization, facility or professional named in section 3 has already released health information based on my consent, my request to stop will not work for that health information.

I understand that when the health information specified in section 5 is sent to the third party named in section 4, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.

I understand that if the organization named in section 4 is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

If I choose not to sign this form and the organization named in section 4 is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:

Date ___ / ___ / _____ Or specific event _____
MM DD YYYY

9 Patient's signature

_____ Date ___ /___ /_____
MM DD YYYY

OR legally authorized representative's signature _____ Date ___ /___ /_____
MM DD YYYY

Representative's relationship to patient (parent, guardian, etc.) _____

PRINT FORM

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of any individual or family member of the individual, except as specifically allowed by this law.

This form was approved by the Commissioner of the Minnesota Department of Health on January 30, 2008 and updated in August 2015.

Minnesota Standard Consent Form to Release Health Information

1 Patient information

First name _____ Middle name _____ Last name _____

Patient date of birth ___ / ___ / _____ (MM / DD / YYYY) Previous name(s) _____

Home address _____

City _____ State _____ Zip code _____

Daytime phone _____ E-mail address (optional) _____

Medical Record/patient ID number (optional) _____

2 Contact for information about how this form was filled out (optional):

I give permission for the organization(s) listed in section 3 permission to talk to

First name _____ Last name _____ about how this form was completed,

this person can be reached at: Daytime phone _____ E-mail address (optional) _____

3 I am requesting health information be released from at least one of the following:

Organization(s) name _____

Specific health care facility or location(s) _____

Specific health care professional's name(s) _____

4 I am requesting that health information be sent to:

Organization(s) name _____

And/or person: First name _____ Last name _____

Mailing address _____

City _____ State _____ Zip code _____

Phone (optional) _____ Fax (optional) _____

Information needed by (date) ___ / ___ / _____ (MM / DD / YYYY) (optional)

5 Information to be released

IMPORTANT: indicate only the information that you are authorizing to be released.

☐ Specific dates/years of treatment _____

☐ All health information *(see description in instructions for what is included)*

OR to only release specific portions of your health information, indicate the categories to be released:

☐ History/Physical	☐ Mental health	☐ HIV/AIDS testing
☐ Laboratory report	☐ Discharge summary	☐ Radiology report
☐ Emergency room report	☐ Progress notes	☐ Radiology image(s)
☐ Surgical report	☐ Care plan	☐ Photographs, video, digital or other images
☐ Medications	☐ Immunizations	☐ Billing records

☐ Other information or instructions _____

The following information requires special consent by law. Even if you indicate **all health information,** you must specifically request the following information in order for it to be released:

☐ Chemical dependency program *(see definition in instructions)*

☐ Psychotherapy notes *(this consent cannot be combined with any other; see instructions)*

Minnesota Standard Consent Form to Release Health Information

Patient's name _____

6 Health information includes written and oral information

By indicating any of the categories in section 5, you are giving permission for written information to be released **and** for a person in section 3 to talk to a person in section 4 about your health information.

If you do not want to give your permission for a person in section 3 to talk to a person in section 4 about your health information, indicate that here (check mark or initials) _____

7 Reason(s) for releasing information

- ☐ Patient's request
- ☐ Review patient's current care
- ☐ Treatment/continued care
- ☐ Payment
- ☐ Insurance application
- ☐ Legal
- ☐ Appeal denial of Social Security Disability income or benefits
- ☐ Marketing purposes (payment or compensation involved? ☐ NO ☐ YES, amount_____)
- ☐ Sale (payment or compensation to entity maintaining the information? ☐ NO ☐ YES)
- ☐ Other (please explain) _____

8

I understand that by signing this form, I am requesting that the health information specified in Section 5 be sent to the third party named in section 4.

I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in section 3.

If the organization, facility or professional named in section 3 has already released health information based on my consent, my request to stop will not work for that health information.

I understand that when the health information specified in section 5 is sent to the third party named in section 4, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.

I understand that if the organization named in section 4 is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

If I choose not to sign this form and the organization named in section 4 is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:

Date ___ / ___ / _____ Or specific event _____
MM DD YYYY

9 Patient's signature

_____ Date ___ /___ /_____
MM DD YYYY

OR legally authorized representative's signature _____ Date ___ /___ /_____
MM DD YYYY

Representative's relationship to patient (parent, guardian, etc.) _____

PRINT FORM

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of any individual or family member of the individual, except as specifically allowed by this law.

This form was approved by the Commissioner of the Minnesota Department of Health on January 30, 2008 and updated in August 2015.

Diagnoses

My Child's Name _____

Diagnosis	Abbrev.	Doctor(s) who diagnosed	Doctors' Specialty	Date of diagnosis	Notes
Acute Stress Disorder	*ASD*	*Dr. Moana*	*Psychiatrist*	*1/6/2015*	*Need to watch to see if this turns into PTSD*

Medications

My Child's Name _____

Medication	Dosage	Time of day	Start Date and Reason	End Date and Reason	Ordered by	Notes (Improvements and side effects)
Lexapro	*20 mg*	*Bedtime*	*11/1/2016 Depression*	*12/15/2018 Slowed growth rate*	*Dr. Maui*	*Less suicidal thinking*

Medications

My Child's Name _____

Medication	Dosage	Time of day	Start Date and Reason	End Date and Reason	Ordered by	Notes (Improvements and side effects)
Lexapro	*20 mg*	*Bedtime*	*11/1/2016 Depression*	*12/15/2018 Slowed growth rate*	*Dr. Maui*	*Less suicidal thinking*

Hospital/ Facility Stays

My Child's Name _____

Reason for Admission	Admission Date	Discharge Date	Hospital/Agency, Doctor	Telephone	Notes
Appendix removed	*5/5/2014*	*5/7/2014*	*Tefiti Regional, Dr. HeiHei*	*555-444-3333*	*Surgery successful*

Treatment History

My Child's Name _____

Treatment	Start Date	End Date	Provider	Notes (What worked? What didn't?)
TF-CBT	*6/1/15*	*Current*	*Dr. Tamatoa*	*Had less nightmares and tantrums after this! We felt closer after she shared her story in therapy*

FAMILY Medical History

My Child's Name _____

Has anyone in your child's family experienced these physical health disorders:

X	Condition	Family Member	Notes
☐	Genetic Conditions		
☐	Heart Problems		
☐	Developmental disability		
☐	Seizure disorder		
☐	Diabetes		
☐	Blood disorder		
☐	Cancer		
☐	Vision or hearing impairment		
☐	Metabolic or nutritional disorder		
☐			
☐			

Has anyone in your child's family experienced these mental health disorders:

X	Condition	Family Member	Notes
☐	Depression		
☐	Anxiety		
☐	Bi-Polar Disorder		
☐	Post-Traumatic Stress Disorder		
☐	Drug or Alcohol Addiction		
☐	Schizophrenia		
☐			
☐			

CHILD Medical History My Child's Name _____

X	Condition	Notes
☐	Asthma	
☐	Blood disorder	
☐	Bone/Joint problems	
☐	Bowel control problems	
☐	Cancer	
☐	Chickenpox	
☐	Developmental disability	
☐	Diabetes	
☐	Ear infection	
☐	Eczema	
☐	Excessive vomiting	
☐	Genetic Conditions	
☐	German Measles (Rubella)	
☐	Heart Problems	
☐	Infectious Mononucleosis	
☐	Measles (Rubeola)	
☐	Meningitis	
☐	Metabolic/nutritional disorder	
☐	Mumps	
☐	Pertussis (Whopping Cough)	
☐	Respiratory Infections	
☐	Rheumatic Fever	
☐	Roseola	
☐	Scarlet Fever	
☐	Seizure disorder	
☐	Strep Throat	
☐	Vision or hearing impairment	
☐		
☐		
☐		
☐		
☐		
☐		
☐		
☐		

Allergies

My Child's Name _____

Allergy	Type of Reaction

Past Stressful Experiences or Trauma

My Child's Name _____

Has your child experienced any of the following?

X	Condition	Notes
☐	Bullying	
☐	Death of a loved one	
☐	Domestic violence	
☐	Emotional abuse	
☐	Gun violence	
☐	Homelessness	
☐	Loss of a pet	
☐	Not enough food	
☐	Parent in Jail	
☐	Physical abuse	
☐	Separation from parents	
☐	Severe Illness or surgery	
☐	Sexual abuse	
☐	War or refugee experience	

Visit Summary

My Child's Name _____

Date	
Doctor's Name	
Specialty	
Reason for Visit	
Summary of Findings	
Plan	

REMEMBER: update diagnoses or changes in medication and/or dosage in your Care Binder.

Visit Summary

My Child's Name _____

Date	
Doctor's Name	
Specialty	
Reason for Visit	
Summary of Findings	
Plan	

REMEMBER: update diagnoses or changes in medication and/or dosage in your Care Binder.

Visit Summary

My Child's Name _____

Date	
Doctor's Name	
Specialty	
Reason for Visit	
Summary of Findings	
Plan	

REMEMBER: update diagnoses or changes in medication and/or dosage in your Care Binder.

Visit Summary

My Child's Name _____

Date	
Doctor's Name	
Specialty	
Reason for Visit	
Summary of Findings	
Plan	

REMEMBER: update diagnoses or changes in medication and/or dosage in your Care Binder.

School

Other Documents That I Could Add to This Section:

- ☐ IEP/ 504 or BIP
- ☐ Report Cards and Progress Reports
- ☐ School Handbook: (look for policies on discipline; behavior; bullying; restorative practices etc.)
- ☐ School Calendar
- ☐ Release of Information Forms
- ☐
- ☐
- ☐

School Info My Child's Name _____

Name of School/Program	
Name of School District	
School Principal	
Assistant Principal	
Grade	
Home Room Teacher (if this applies)	

Other School Services (e.g. occupational therapist (OT), physical therapist (PT), remedial reading, speech, social worker, school nurse, etc.)

Service	Name of School Staff or School-Based Staff

School History

Years	Name of School/Program	Reason for Leaving

School Meeting

Child Name _____

Date	Meeting Purpose	Who was at the Meeting?	Results/Notes
10/25/2020	*IEP Meeting*	*Principal, Teacher, School Nurse, Mom, Child, Math Teacher, Social Worker*	

School Meeting

Child Name _____

Date	Meeting Purpose	Who was at the Meeting?	Results/Notes
10/25/2020	*IEP Meeting*	*Principal, Teacher, School Nurse, Mom, Child, Math Teacher, Social Worker*	

School Meeting

Child Name _____

Date	Meeting Purpose	Who was at the Meeting?	Results/Notes
10/25/2020	*IEP Meeting*	*Principal, Teacher, School Nurse, Mom, Child, Math Teacher, Social Worker*	

School Meeting

Child Name _____

Date	Meeting Purpose	Who was at the Meeting?	Results/Notes
10/25/2020	*IEP Meeting*	*Principal, Teacher, School Nurse, Mom, Child, Math Teacher, Social Worker*	

IEP Worksheet (1)

At the Meeting

Arrive Early and Be Prepared

Arrive at least 15 minutes before your meeting starts. Bring your IEP worksheets and your child's Care Binder. If possible, ask the school to make copies of your IEP worksheets BEFORE the meeting so that everyone on the team has a chance to look at them. Try to limit your concerns/worries to no more than 4 things.

Stay Calm

IEP meetings can be stressful and emotional. Practice some of your "calm parenting" tricks.

- Cooperate
- Be respectful
- Stay positive

Take Notes

You will need detailed notes of your meeting. Ask if you can tape record the meeting or bring someone with you who can take notes.

Ask for Introductions

Ask everyone at the table to introduce themselves and how they know your child. Make sure you put this info in your notes.

Use Your IEP Worksheets

If you haven't shared your IEP worksheets before the meeting, do so now. Use your worksheets to stay on track and to remember everything that you want to talk about.

Finalize the IEP

Make sure your child's IEP says what you want it to say before you sign it. You don't have to sign it at this meeting. If you want to review it at home or with a family advocate, ask to have some time before you sign it. If you need a family advocate to follow up with the school, remember to sign any necessary releases of information.

Special Needs/ Mental Health: Include each date of diagnosis or assessment.

What I would like you to know about my child: Short description of your child's likes, dislikes, personality, favorite toys and activities, new interests, relationships with family members, connections in the community etc. Also share any changes at home (divorce etc.)

These are some areas of strength for my child: Does the IEP team agree or disagree with your list? If you have a hard time with this, ask the IEP team to offer their suggestions.

These are some things that worry me. Examples of concerns- "I am worried because Joe can't…." OR "I want Tanisha to be able to …."

1.
2.
3.
4.

IEP Worksheet (3)

One concern/worry that I have…	
The evidence. How I know there is a problem…	
What stuff might be happening that is causing the problem or making it worse	
Kinds of tests or assessments that might be needed	
A goal and objective for my child. Ex. I want Tanisha to … Joe will be able to…	
Based on my understanding of my child's disability, these are services or supports that I think could help.	
Agreements reached with IEP team	
Who is going to do what before our next meeting?	

IEP Worksheet (3)

One concern/worry that I have…	
The evidence. How I know there is a problem…	
What stuff might be happening that is causing the problem or making it worse	
Kinds of tests or assessments that might be needed	
A goal and objective for my child. Ex. I want Tanisha to … Joe will be able to…	
Based on my understanding of my child's disability, these are services or supports that I think could help.	
Agreements reached with IEP team	
Who is going to do what before our next meeting?	

IEP Worksheet (3)

One concern/worry that I have…	
The evidence. How I know there is a problem…	
What stuff might be happening that is causing the problem or making it worse	
Kinds of tests or assessments that might be needed	
A goal and objective for my child. Ex. I want Tanisha to … Joe will be able to…	
Based on my understanding of my child's disability, these are services or supports that I think could help.	
Agreements reached with IEP team	
Who is going to do what before our next meeting?	

IEP Worksheet (3)

One concern/worry that I have…	
The evidence. How I know there is a problem…	
What stuff might be happening that is causing the problem or making it worse	
Kinds of tests or assessments that might be needed	
A goal and objective for my child. Ex. I want Tanisha to … Joe will be able to…	
Based on my understanding of my child's disability, these are services or supports that I think could help.	
Agreements reached with IEP team	
Who is going to do what before our next meeting?	

Beginning of the School Year

At the beginning of the year, set aside some time to meet with school staff. Bring your Care Binder! Fill out and update forms together. If school staff need to print blank pages or extra pages, visit: https://www.rccmhc.org/all-in-one-place

☐ Fill in or update School Contact form

☐ Sign Release of Information Forms so that the school can talk to hospital/providers etc.

Don't forget to sign a Release of Information for the Children's Crisis Response Team if you want them to come to the school in a crisis or provide stabilization services after a crisis.

☐ Review medical forms- especially the Emergency Information Form (EIF). Ask School to keep a copy and provide to EMS.

☐ Discuss your child's Crisis Plan. Ask the school to keep a copy.

☐ Discuss the Crisis Communication form. Ask the school to keep a blank copy and fill it out in a crisis. On the day of the crisis, the school should give the completed form to EMS or to you to carry to the ER.

☐ Recent Family Changes and Stress

☐ Triggers and Warning Signs

☐ Coping

During the year, you may also want to discuss:

- Child/Teen Strengths
- IEP Worksheets

PACER provides individual assistance, workshops, publications, and other resources to help families make decisions about education and other services for their child or young adult with disabilities.

952.838.9000

Email: https://www.pacer.org/forms/

Website: https://www.pacer.org/

School Info Sheet (during COVID-19)

for students who are in online or hybrid school programs during COVID-19

Student's Name & Grade	
School District & School	

PARENT/ CAREGIVER

User Name or Email	
Password	

STUDENT

Student ID/ User Name	
Password	
Student Email	

School Services (e.g. principal, occupational therapist (OT), physical therapist (PT), remedial reading, speech, school nurse, social worker, dean, counselor, liaison, IEP Case Manager)

Service	Name	Email	Phone

Mental Health

(crisis and coping)

Other Documents That I Could Add to This Section:

- ☐ Care Plans
- ☐ Health Journals/ Tracking Charts
- ☐ Coping Ideas
- ☐
- ☐

Mental Health Crisis PLAN

Work with your child's support team to plan for a crisis before it happens! Include your child/teen whenever possible. **Make copies of the crisis plan and share it with anyone who might be involved in resolving a future crisis.**

Name (Child/Teen)	
Birthdate (Child/Teen)	
Name (Parents/Caregivers)	
Phone Number (Parents/Caregivers)	
Preferred Hospital- Medical	
Preferred Hospital- Mental Health	
Mental Health Diagnoses	
Important Medical History (See also EIF Form)	
Medications	
Providers (Family doctor, therapist, case manager, psychiatrist…)	
Triggers (What usually happens before the crisis behavior)	

Strategies/Treatment- YES! (What works) ☺	
Strategies/Treatment- NO! (What doesn't work) ☹	
Safety Plan (Remove all weapons and sharp objects. Lock up all medications. Plan to keep other people in the home safe…)	
When to call Children's Crisis Response (651) 266-7878	
If my child is at school during a crisis, I want them to contact the Child Crisis Response Team. ☐ YES Details:	
When to call an Ambulance or go to ER	
When to dial 911	
Parent/Caregiver Signature and Date	

Remember to update your Crisis Plan whenever there is a change in diagnosis, medication, treatment or providers. And, always work with hospital staff to update your Crisis Plan before discharge.

Mental Health Emergency

A Checklist for Parents/Caregivers

Crisis

A mental health CRISIS occurs when youth cannot manage emotional or behavioral distress on their own. Your child needs help from you, from a trusted adult, and/or from a professional.

- ☐ Use your child's Crisis Plan. Support your child with calm down strategies. Call the Ramsey County Child Crisis Response Team. 651-266-7878 (24 hours a day, 7 days a week)
- ☐ Call your child's doctor or mental health provider.
- ☐ Are YOU doing ok? Don't try to manage everything by yourself! Ask for support from friends, family, a respite provider, an adult mental health provider, and/or faith leader.

Emergency- 911

If there is danger, it is a mental health EMERGENCY. Dial 911.

- ☐ Is your child in danger of hurting self or others? Have harmful actions already been taken (hurting someone, taking an overdose of medication, or pulling out a weapon…)?
- ☐ Is your child intoxicated? Does your child have a self-injury that requires medical attention?
- ☐ Is your child acting strangely or in ways that endanger your child's safety or other's safety (behavior that is unpredictable, behavior that the child/teen isn't able to control…)?
- ☐ Ask the 911 operator to send a CIT (Crisis Intervention Team) police officer if one is available

While You Wait

- ☐ Breathe. Manage your own response. (Relax, Reflect, Respond)
- ☐ Don't engage with power struggles or attempts to pick a fight.
- ☐ Talk softly and calmly, move slowly, avoid continuous eye contact. Give personal space.
- ☐ Use open-ended questions, express support, offer options and calm down strategies.
- ☐ LISTEN, EMPATHIZE, AGREE wherever possible, and PARTNER in ways that support your child's need for control and safety (LEAP method)
- ☐ Ask a friend or family member to babysit your other children.

Bring to the Emergency Department

(if there is time)

- ☐ Your Family Care Binder or past medical history and insurance info. Also bring the medications that your child is currently taking (or bring a list of current medications.)
- ☐ Any other medicine or drugs that may have been taken by your child.
- ☐ Filled-out forms: Crisis Communication, Emergency Information Form, Consent to Release Information
- ☐ A Calm Down Toolkit, snack and drink, fidgets, distracting activities, headphones or earplugs…
- ☐ A friend or family member who can help you take notes.

Ambulance

- [ ] If needed, ask if your child can hold a comfort item or wear over the ear headphones/earplugs.
- [ ] If your child needs immediate medical help, the ambulance will go to the closest appropriate hospital. If there is not an immediate medical emergency, you can ask the ambulance to take you to your hospital of choice. (This might not be possible if the ED is "on divert.") The following Emergency Departments are affiliated with a hospital that offers inpatient services for youth:

  Ages 5 to 18
  - Abbott NW Hospital 612-863-4000
  - Fairview/ M Health 612-273-5640

  Ages 12-18
  - United Hospital 651-241-8000

- [ ] In some situations, a parent/caregiver can ride with the ambulance. Riding with the ambulance will help you arrive at the same time as your child so you can participate in any information exchange between the ambulance and the Emergency Department team. (If you ride in the ambulance, remember that you will need to find a ride home.)

Emergency Department (ED)

Wait times can be long! ED doctors will help the people with the worst illnesses and injuries first.

- [ ] If you think your child is getting worse, tell the nurse so your child can be rechecked.

In a mental health emergency, the #1 goal is safety. The doctors need to figure out what's going on so they can provide treatment. They will ask lots of questions. They will talk to you and they will also talk to your child (without you in the room.) They might run medical tests. And, they will observe your child.

- [ ] Connect the ED to school staff and/or mental health providers who may have additional info.
- [ ] Ask if your child will be evaluated by a mental health professional.
- [ ] Ask your child's nurse about language interpreters, social workers or child life specialists. Child Life Specialists might be available to help reduce anxiety with distracting activities. And, Social Workers might be available to offer support and local resources.

Hospital Admission

Very few children/teens are hospitalized for mental health treatment. However, if there are still safety concerns after your child has been treated in the ED, your child may need to be admitted to the hospital.

Discharge- Going Home

Your child will be discharged from the ED when the doctors think it is safe to continue diagnostic workups or treatment outside of the hospital (intensive outpatient care, day treatment, residential treatment etc.)

- [ ] If you do not agree that your child is safe- explain your concerns and ask questions.
- [ ] You will be given discharge instructions. Use a Discharge Checklist and try to take notes. Ask hospital staff to help you update your child's crisis plan and medication list before you leave. Remember to share this with your child's school and care team.
- [ ] Ask if the hospital can set up a follow up appointment with a provider before you leave.
- [ ] Ask about stabilization services through Ramsey County Child Crisis Response 651-266-7878

Crisis COMMUNICATION

Give this form to Ambulance/EMS, Police, Emergency Room or other providers who are responding to the youth in crisis. This form should be completed by the Crisis Observer

Name (Child/Teen)	
Age and DOB (Child/Teen)	
Name (Parents/Caregivers)	
Phone Number (Parents/Caregivers)	
Family's Preferred ER- Medical	
Family's Preferred ER- Mental Health	
Date of Crisis	
Location of Crisis	
Your Name (the crisis observer)	
Relationship to Child/Teen Include your job title and school or agency	
Observer's Contact Info Include your contact hours and other follow up instructions	
Child/Teen's Current Clinical Status Information on dysregulation of mood and behaviors from base line	
Trigger(s) What happened immediately BEFORE the crisis?	

Description of Crisis Behavior and Mechanism of Injury List any drugs, poisons, or medications that you think the child/teen may have taken. If you have the substance or the medicine bottle- send it to the ER.	
Crisis Intervention(s) Describe any interventions that were tried for this crisis. Include any medications that were given.	
Strategies/Treatment- YES! What has worked well in the past.	
Strategies/Treatment- NO! What has *not* worked well in the past.	
Services What services does the child receive?	
Additional Information & History • Context • Frequency • Duration • Intensity • Plan (intent) • Access to lethal means • Safety concerns • Recent changes or increased stress • Has EMS/ ER been used before?	

Other forms to provide: Emergency Information Form, MN Standard Consent to Release Information, Recent Family Changes or Stress, About My Child/Teen, Past Stressful Experiences or Trauma, and other medical history information.

EMS/Ambulance--- Transition of Care

EMS providers have their own forms. They upload this info electronically so that ER doctors can read the details. But this form could be used if an extra paper copy is desired.

Date	
EMS Agency	
Observation Summary (Scene Size-Up)	
Attempts at Procedures	
Primary Assessment and Vitals	
	Pulse Rate
	Temperature
	Respiration
	Blood Pressure
Secondary Assessment and Vitals	
	Pulse Rate
	Temperature
	Respiration
	Blood Pressure

Re- Assessment and Vitals	
	Pulse Rate
	Temperature
	Respiration
	Blood Pressure
Medications Administered	
Clinical Status and Examination Findings (Including changes in patient condition during transport)	
Estimated Weight (by length-based tape or parental report)	
Authorized Signature	
---- Attach the Emergency Information Form (EIF) or fill in sections below ----	
Health History and Preexisting Conditions	
Allergies	

Discharge Checklist

Use this checklist when your child is discharged from the Emergency Department, Hospital, or other in-patient program.

✓	Description	Things to Consider
☐	Accessibility	Do you know who to call if problems arise at home? • Do you have 24/7 telephone access to a healthcare provider who is familiar with your child and/or has access to your child's medical summary and care plans?
☐	Care Environment (Home, Car, School, Community…)	Is your child's care environment safe, accessible and adequate to meet your child's needs? • Do you need supplies such as a lockbox to keep medicines and dangerous items out of reach? • Do you need help with a task such as setting the child-lock safety feature in your car? • Do you need a plan to keep your child safe? • Do you need a plan to keep other people in the house safe? • Do you have a functioning telephone? • Are other adaptations needed?
☐	Caregiver/Parent (Health and Capabilities)	How are YOU? • How is your stress, mental health, tiredness, physical health, or emotional distress? • Can you care for your child/ children? • Do you feel confident that you can follow your child's care plan and crisis plan? Are you confused about anything? • Do you know your child's medications and when to give them? • Are you able to give medications on time/ correct doses? • Do you know the signs of drug use or overdose? (if relevant) • Are you able to keep your child safe? • If you have concerns… talk to a medical professional and make a plan <u>before</u> discharge.
☐	Communication	What is the discharge communication plan? • Did you fill out all necessary release of information forms? • Has a care summary been sent to your child's primary care doctor? • If you need to select a primary care doctor, ask to talk to a social worker. • Will the hospital communicate with your child's school? How?

☐	Community Resources	What community resources are available to help your child and family? • Can a hospital social worker connect you with local agencies or services? • Do you have access to respite services (county, community, or faith-based?
☐	Crisis Plan	Work with hospital staff to update the Crisis Plan in your Care Binder. • Do you need stabilization services with the Ramsey County Child Crisis Response Team?
☐	Discharge Summary	Were you given a discharge summary? • Put it in your Care Binder or take a photo of it with your phone. • If you are NOT given a written summary, ask a medical professional to fill out one of the Visit Summary forms in your Care Binder. • What are the discharge goals?
☐	Follow Up Plan	What is the follow-up plan?
☐	Financial/Job	• Do you need a Doctor's Note for your job? Will you have to miss work for a few days? • Do you need help with any financial or insurance forms?
☐	Medical Equipment or Supplies	Do you need any equipment or supplies to provide care at home? • How will you get the supplies? • Will costs be covered by Medicaid/ Insurance?
☐	Medical Stability	Do you understand your child's diagnosis and agree that your child is medically stable? • If you do NOT agree- ask a medical professional to explain.
☐	Medication List	Work with hospital staff to update the Medication List in your Care Binder.
☐	Medications	• Are there any new medicines or different doses? • Were any medications stopped? • Are all medicines OK do be taken together? • Where and when will new medicines be filled? • Does your child take the medicine reliably? • Should you stop giving certain over the counter medicines? • Is medicine timed so it doesn't disrupt sleep or schedules?

☐	Social Supports	What are your family's emotional, cultural, religious or extended family and social supports? • How can they help? • Will you reach out for support now—or when you get home?
☐	Transition Plan	What is the plan to help your child transition to the next care environment? • Transition to home care? • Transition back to school? • Other transition to inpatient or day treatment?
☐	Transportation	Do you have transportation? • How are you getting home? • Does your child need someone other than the driver in the car during transportation?
☐	Willingness to Go Home	Is your child/ are you ready to go home? (If not, why not?) • Explain your concerns and ask questions.

IDEA: During discharge, if it is too hard for you to take notes…ask if you can use your phone to record your discussion. Or, ask a friend/family member to take notes for you.

NOTES

Triggers and Warning Signs

What things make your child feel sad, mad, or scared?

- ◯ Anniversaries of trauma (such as past abuse or past deaths)
- ◯ Arguments or fights in the family
- ◯ Criticism
- ◯ Yelling
- ◯ Being around certain people
- ◯ Being separated from a parent, sibling, or friend
- ◯ Feeling dumb or not understanding
- ◯ Being sick, hungry or tired
- ◯ Feeling overwhelmed
- ◯ Being told "no"
- ◯ Tests/homework
- ◯ Having a relationship end
- ◯ Financial problems
- ◯ Going between caregiver homes
- ◯ Bullying at school
- ◯ Holding down/restraining
- ◯ Getting in personal space-touching/pushing
- ◯ Discrimination or feeling disrespected
- ◯ Missed medication
- ◯ Important event coming up (like court)
- ◯ Being in crowds
- ◯ Community violence
- ◯ Sexual comments/harassment
- ◯ Loud noises
- ◯ _____
- ◯ _____

How can you tell when your child is not feeling good?

- ◯ Stops bathing or brushing hair
- ◯ Changes in appetite
- ◯ Sleeps all day or not at all
- ◯ Suddenly feels depressed
- ◯ Suddenly feels happy or calm after feeling depressed
- ◯ Constant pacing
- ◯ Starts yelling
- ◯ Destroys property
- ◯ Hurts animals
- ◯ Uses alcohol or drugs
- ◯ Cuts or burns themselves
- ◯ Dresses differently
- ◯ Can't recognize family or friends
- ◯ Has strange ideas
- ◯ Picks fights/ gets into fights
- ◯ Hears or sees things that are not there
- ◯ Withdraws from friends or family
- ◯ Loses interest in fun activities
- ◯ Stops going to school or doing homework
- ◯ Does risky or dangerous things
- ◯ Stomachache or headache
- ◯ _____
- ◯ _____

Coping Strategies

What can your CHILD/TEEN do:

- ◯ Play an instrument; ex: harmonica
- ◯ Watch a TV show or Read
- ◯ Paint, art, coloring book
- ◯ Wrap in a blanket; weighted blanket
- ◯ Exercise, stretch, yoga
- ◯ Use a heat pack or cold pack
- ◯ Write in a journal; write a letter
- ◯ Talk on the phone (friend/family)
- ◯ Take a medication
- ◯ Go outside- run, bike, hike…
- ◯ Do a hobby _____
- ◯ Go to a support group
- ◯ Talk with a provider
- ◯ Pray, meditate, take deep breaths
- ◯ Use a fidget
- ◯ Pace or repeat movements
- ◯ Listen to music
- ◯ Hold a favorite stuffed animal
- ◯ Take a bath or shower
- ◯ Use headphones or ear plugs
- ◯ Chew something (gum, fidget)
- ◯ Stick to a routine (meals, sleep etc.)
- ◯ Play a game, do a puzzle or Legos
- ◯ Snuggle or pet an animal
- ◯ Eat a protein snack
- ◯ Drink water or Gatorade etc.
- ◯ Take a nap
- ◯ _____
- ◯ _____

WHO helps your child feel better?

- ◯ Parents
- ◯ Brothers, Sisters
- ◯ Grandparents/ other family
- ◯ Teachers or Coaches
- ◯ Providers
- ◯ Friends
- ◯ _____
- ◯ _____
- ◯ _____
- ◯ _____

HOW can other people help?

- ◯ Listen without giving advice
- ◯ Give a hug or hold tightly
- ◯ Go on a walk together
- ◯ Give things to draw or paint
- ◯ Don't talk
- ◯ Give a medication
- ◯ Play a movie
- ◯ Give encouragement
- ◯ Let them rest
- ◯ Give a massage; play with hair
- ◯ _____
- ◯ _____
- ◯ _____

Behavior/Mood Tracker

My Child's Name _____

Day/Time	Describe Behavior/Mood	How Long Did It Last?	What Happened BEFORE	What Happened AFTER

Behavior/Mood Tracker

My Child's Name _____

Day/Time	Describe Behavior/Mood	How Long Did It Last?	What Happened BEFORE	What Happened AFTER

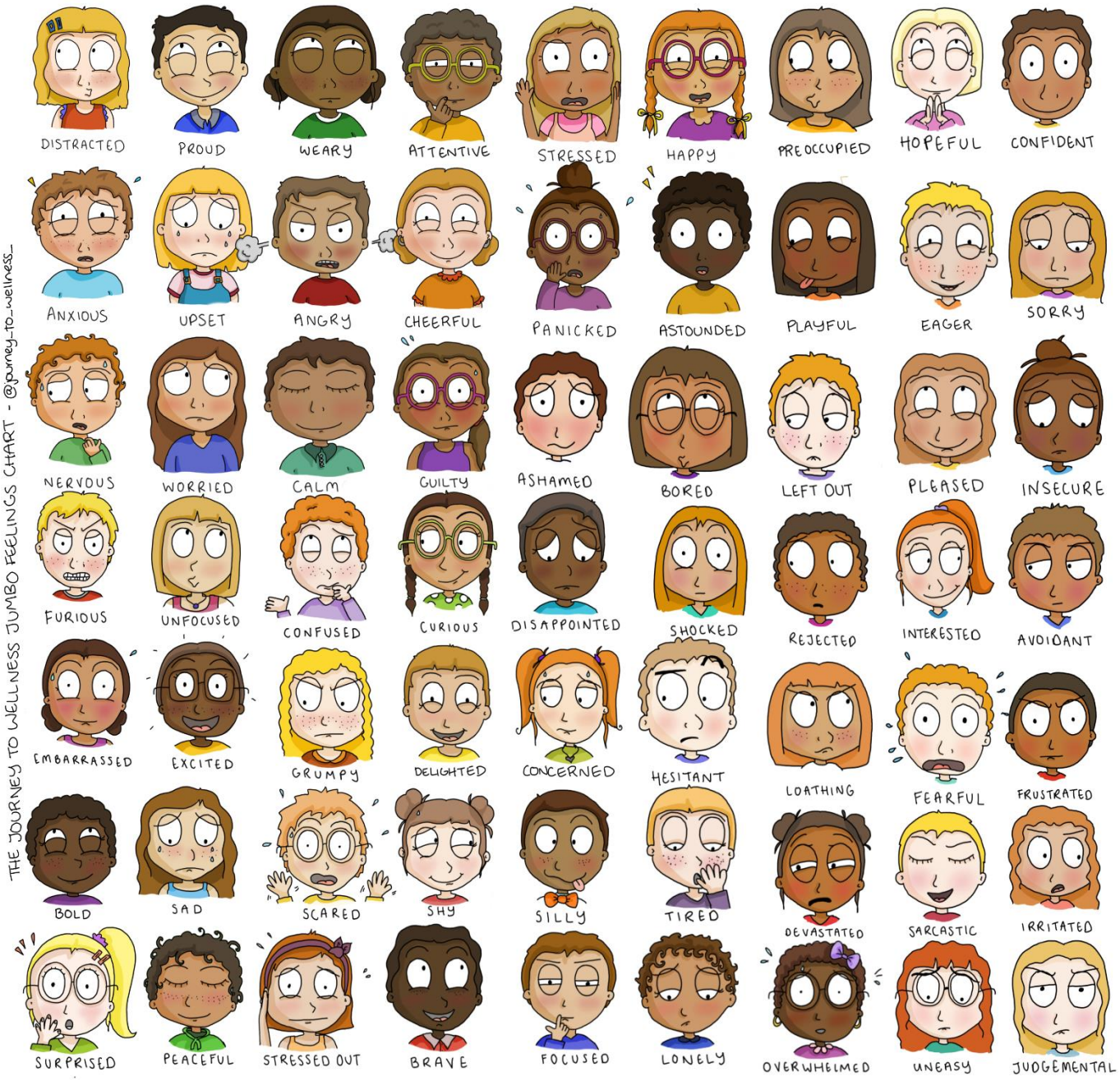
Behavior/Mood Tracker

My Child's Name _____

Day/Time	Describe Behavior/Mood	How Long Did It Last?	What Happened BEFORE	What Happened AFTER

Feelings Chart

Use a feelings chart to help name emotions. If your child is having a hard time, ask your child to show you someone on TV, in a book or online who has the same emotion.

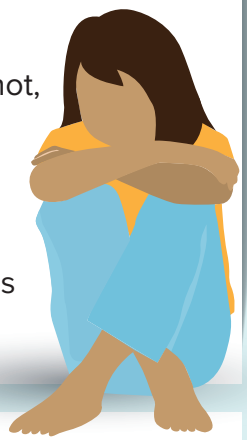


NAVIGATING a mental health CRISIS

WARNING SIGNS of a Mental Health Crisis

It's important to know that warning signs are not always present when a mental health crisis is developing. Common actions that may be a clue that a mental health crisis is developing:

- ✔ **Inability to perform daily tasks** like bathing, brushing teeth, brushing hair, changing clothes
- ✔ **Rapid mood swings**, increased energy level, inability to stay still, pacing; suddenly depressed, withdrawn; suddenly happy or calm after period of depression
- ✔ **Increased agitation** verbal threats, violent, out-of-control behavior, destroys property
- ✔ **Abusive behavior** to self and others, including substance use or self-harm (cutting)
- ✔ **Isolation** from school, work, family, friends
- ✔ **Loses touch with reality (psychosis)**, unable to recognize family or friends, confused, strange ideas, thinks they're someone they're not, doesn't understand what people are saying, hears voices, sees things that aren't there
- ✔ **Paranoia**, suspicion and mistrust of people or their actions without evidence or justification



WARNING SIGNS of Suicide

- **Giving away personal possessions**
- **Talking as if they're saying goodbye** or going away forever
- **Taking steps** to tie up loose ends, like organizing personal papers or paying off debts
- **Making or changing a will**
- **Stockpiling pills or obtaining a weapon**
- **Preoccupation with death**
- **Sudden cheerfulness or calm** after a period of despondency
- **Dramatic changes** in personality, mood and/or behavior
- **Increased drug or alcohol use**
- **Saying things** like "Nothing matters anymore," "You'll be better off without me," or "Life isn't worth living"
- **Withdrawal** from friends, family and normal activities
- **Failed romantic relationship**
- **Sense of utter hopelessness** and helplessness
- **History** of suicide attempts or other self-harming behaviors
- **History** of family/friend suicide or attempts

NAVIGATING a mental health CRISIS

WHAT TO DO if you suspect someone is thinking about suicide

If you notice warning signs or if you're concerned someone is thinking about suicide, don't be afraid to talk to them about it.

START the Conversation by sharing specific signs you've noticed, like:

"I've noticed lately that you [haven't been sleeping, aren't interested in soccer anymore, which you used to love, are posting a lot of sad song lyrics online, etc.] ..."

Then say something like:

- ✔ "Are you thinking about suicide?"
- ✔ "Do you have a plan? Do you know how you would do it?"
- ✔ "When was the last time you thought about suicide?"

If the answer is "Yes" or if you think they might be at risk of suicide, you need to seek help immediately.

- Call a therapist or psychiatrist/physician or other healthcare professional who has been working with the person
- Remove potential means such as weapons and medications to reduce risk
- Call the National Suicide Prevention Line at 1-800-273-8255 or call 911

LISTEN, EXPRESS CONCERN, REASSURE.

Focus on being understanding, caring and nonjudgmental, saying something like:

"You are not alone. I'm here for you"

"I'm concerned about you and I want you to know there is help available to get you through this."

"I may not be able to understand exactly how you feel, but I care about you and want to help."

"You are important to me; we will get through this together."

Please remember, a suicide threat or attempt is a medical emergency requiring professional help as soon as possible.

NAVIGATING a mental health CRISIS

WHAT TO DO
in a mental health crisis

IF YOU ARE WORRIED that you or your loved one is in crisis or nearing a crisis, seek help. Make sure to assess the immediacy of the situation to help determine where to start or who to call.

- **Is the person in danger** of hurting themselves, others or property?
- **Do you have time** to start with a phone call for guidance and support from a mental health professional?
- **Do you need emergency assistance?**

If the situation is life-threatening or if serious property damage is occurring, don't hesitate to call 911 and ask for immediate assistance.

TECHNIQUES that May Help De-esculate a Crisis:

- ✔ Keep your voice calm
- ✔ Avoid overreacting
- ✔ Listen to the person
- ✔ Express support and concern
- ✔ Avoid continuous eye contact
- ✔ Ask how you can help
- ✔ Keep stimulation level low
- ✔ Move slowly
- ✔ Offer options instead of trying to take control
- ✔ Avoid touching the person unless you ask permission
- ✔ Be patient
- ✔ Gently announce actions before initiating them
- ✔ Give them space, don't make them feel trapped
- ✘ Don't make judgmental comments
- ✘ Don't argue or try to reason with the person

When Calling 911 for a Mental Health Emergency

If you don't feel safe at any time, leave the location immediately.

Remember to:
- ✔ Remain calm
- ✔ Explain that your loved one is having a mental health crisis and is not a criminal
- ✔ Ask for a Crisis Intervention Team (CIT) officer, if available

They will ask:
- ✔ Your name
- ✔ The person's name, age, description
- ✔ The person's current location
- ✔ Whether the person has access to a weapon

Information you may need to communicate:
- ✔ Mental health history, diagnosis(es)
- ✔ Medications, current/discontinued
- ✔ Suicide attempts, current threats
- ✔ Prior violence, current threats
- ✔ Drug use
- ✔ Contributing factors (i.e. current stressors)
- ✔ What has helped in the past
- ✔ Any delusions, hallucinations, loss of touch with reality

NAVIGATING a mental health CRISIS

PREPARING for a crisis

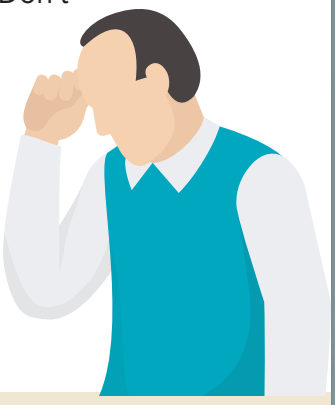
No one wants to worry about the possibility of a crisis—but sometimes it can't be avoided.

It's rare that a person suddenly loses control of thoughts, feelings and behavior. General behavior changes often occur before a crisis. Examples include sleeplessness, ritualistic preoccupation with certain activities, increased suspiciousness, unpredictable outbursts, increased hostility, verbal threats, angry staring or grimacing.

Don't ignore these changes, talk with your loved one and encourage them to visit their doctor or therapist. The more symptomatic your family member becomes, the more difficult it may be to convince them to seek treatment.

If you're feeling like something isn't right, talk with your loved one and voice your concern. If necessary, take action to get services for them and support for yourself.

When a mental health crisis begins, it is likely your family member is unaware of the impact of their behavior. Auditory hallucinations, or voices, may be giving life-threatening suggestions or commands. The person believes they are hearing, seeing or feeling things that aren't there. Don't underestimate the reality and vividness of hallucinations. Accept that your loved one has an altered state of reality and don't argue with them about their experience. In extreme situations, the person may act on these sensory distortions.



If you are alone and feel safe with them, call a trusted friend, neighbor or family member to come be with you until professional help arrives. In the meantime, the following tips may be helpful:

- ✔ **Learn all you can about the illness your family member has.**
- ✔ **Remember** that other family members are also affected, so keep lines of communication open by talking with each other.
- ✔ **Avoid guilt and assigning blame to others.**
- ✔ **Learn to recognize early warning signs of relapse**, such as changes in sleeping patterns, increasing social withdrawal, inattention to hygiene, and signs of irritability.
- ✔ **Do what your loved one wants, as long as it's reasonable and safe.**
- ✘ **Don't shout or raise your voice.**
- ✘ **Don't threaten**; this may be interpreted as a play for power and increase fear or prompt an assault.
- ✘ **Don't criticize or make fun of the person.**
- ✘ **Don't argue with other family members**, particularly in your loved one's presence.
- ✘ **Avoid direct, continuous eye contact or touching the person.**
- ✘ **Don't block the doorway or any other exit.**

NAVIGATING a mental health CRISIS

A CRISIS PLAN

A crisis plan is a written plan developed by the person with the mental health condition and their support team, typically family and close friends. It's designed to address symptoms and behaviors and help prepare for a crisis. Every plan is individualized, some common elements include:

- Person's general information
- Family information
- Behaviors present before the crisis occurs, strategies and treatments that have worked in the past, a list of what actions or people that are likely to make the situation worse, a list of what helps calm the person or reduces symptoms
- Current medication(s) and dosages
- Current diagnoses
- History of suicide attempts, drug use or psychosis
- Treatment choices/preferences
- Local crisis lines
- Addresses and contact information for nearby crisis centers or emergency rooms
- Mobile crisis unit information, if there is one in the area
- Contact information for healthcare professionals (phone and email)
- Supports - adults the person has a trusting relationship with such as neighbors, friends, family members, favorite teacher or counselor at school, people at faith communities or work acquaintances
- Safety plans

The crisis plan is a collaboration between the person with the mental health condition and the family. Once developed, the plan should be shared by the person with involved family, friends and professionals. It should be updated whenever there is a change in diagnosis, medication, treatment or providers. A sample crisis plan can be obtained at www.nami.org.

Our Family

Other Documents That I Could Add to This Section:

- ☐ Custody Plan and Schedule
- ☐ Temporary Guardianship form
- ☐
- ☐

About Our Family

Name	Age	Relationship (Ex. Sister)	Phone Number

Language spoken at home: _____ **Religion:** _____

Favorite things to do as a family:

Family culture and/or traditions:

Family rules:

Pets:

Other special family members or friends:

Recent Family Changes or Stress

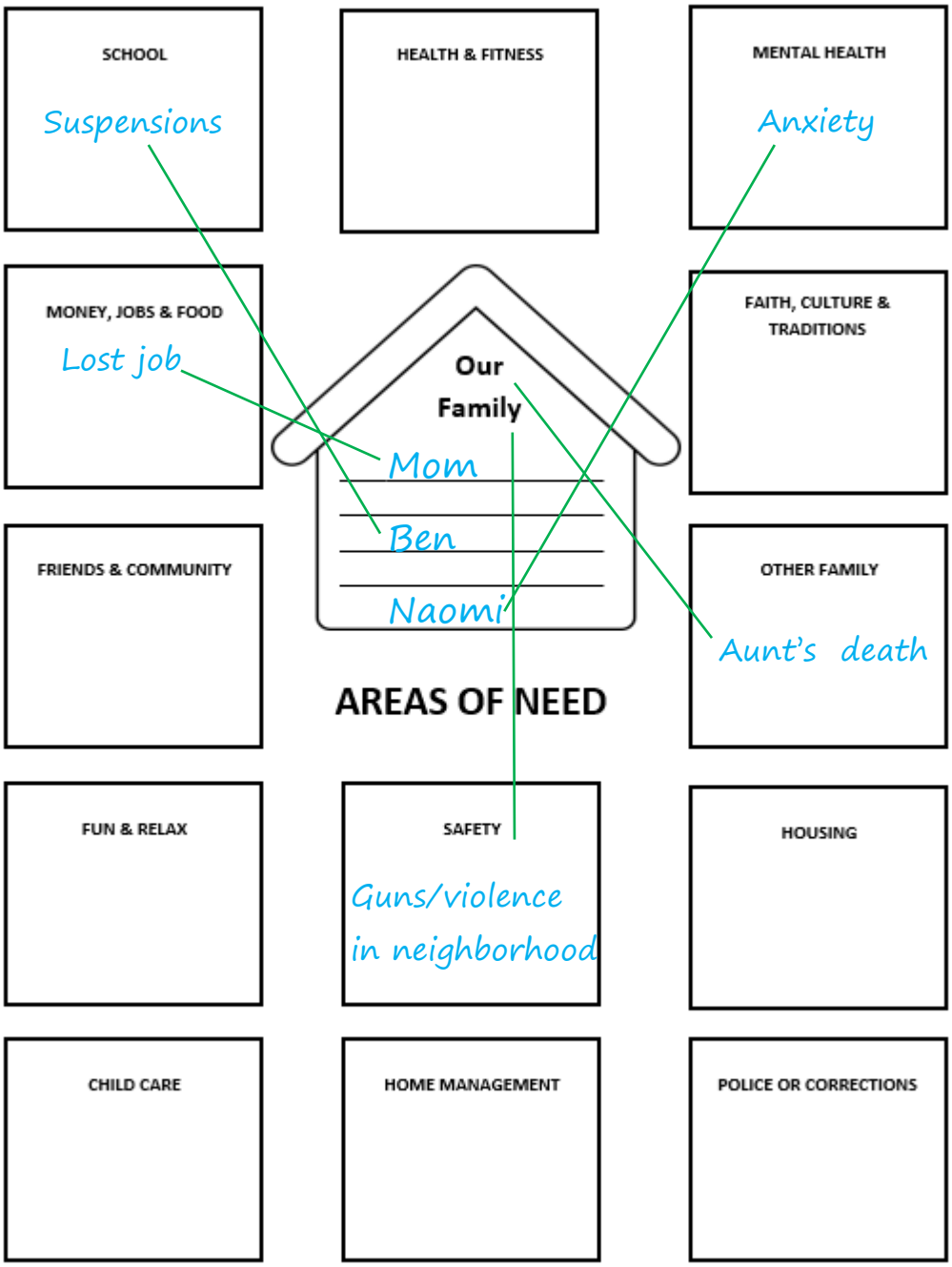
Are there any recent changes or stressors in your family that might affect your child's emotions, behaviors, or physical health?

Change or Stress	How this affects my child	How we are managing the change/stress
☐ Change in financial situation		
☐ Change in job duties		
☐ Child starting a new school or program		
☐ Death of family member or close friend		
☐ Divorce/separation or relationship problems		
☐ Moving to a new home		
☐ A new family member (new baby, foster child, new spouse etc.)		
☐ Parent beginning or leaving a job		
☐ Pregnancy (parent or teen)		
☐ Trouble at school or bullying		
☐ Death or loss of a pet		
☐		
☐		

Ecomap

An “ecomap” is a picture of your family and how you are connected to other people and resources. It can help you tell your story. Ecomaps can be drawn in different ways. In this Care Binder, we created a page for Needs/Challenges and a page for Resources/Supports. The categories are the same on each page. If a category doesn’t make sense for your family, just cross it out or change it to something else.

Sample:

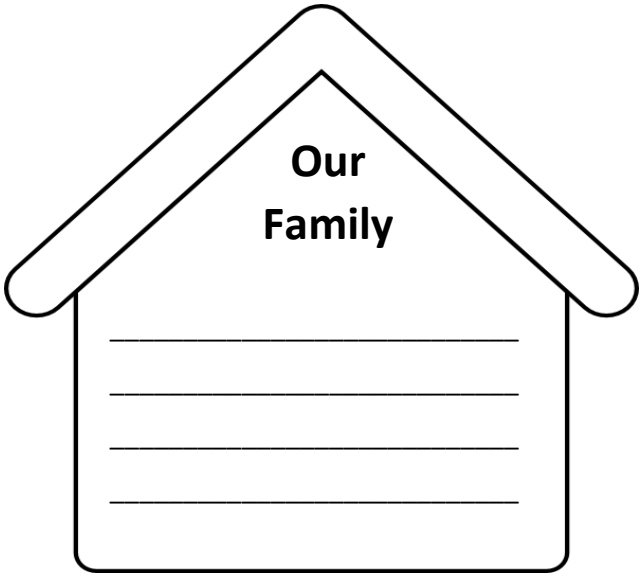


SCHOOL

HEALTH & FITNESS

MENTAL HEALTH

MONEY, JOBS & FOOD



FAITH, CULTURE & TRADITIONS

FRIENDS & COMMUNITY

OTHER FAMILY

NEEDS/CHALLENGES

FUN & RELAX

SAFETY

HOUSING

CHILD CARE

HOME MANAGEMENT

POLICE OR CORRECTIONS

SCHOOL

HEALTH & FITNESS

MENTAL HEALTH

MONEY, JOBS & FOOD

FAITH, CULTURE & TRADITIONS

FRIENDS & COMMUNITY

OTHER FAMILY

RESOURCES & SUPPORTS

FUN & RELAX

SAFETY

HOUSING

CHILD CARE

HOME MANAGEMENT

POLICE OR CORRECTIONS

About My Child/Teen

Full Name _____ **Date of Birth** _____

Nickname _____

My child lives at…. ☐ My Home ☐ Other Parent/Family Home ☐ Foster Home ☐ Hospital/ In-Patient ☐ Other _____

	Eye color: Hair color: Height: Weight: Race/Ethnicity: Gender: Language(s): Special Description (Example: a birthmark):

My Child's Favorite Things

Color _____ Apps _____

Toy _____ Hobby _____

TV _____ Song _____

Movie _____ Other _____

Game _____

More About My Child/Teen

Foods- YES!	
Foods- NO!	
Activities- YES!	
Activities- NO!	
Sensory- YES! (Things in the environment that help and soothe my child.)	
Sensory- NO! (Things in the environment that hurt or bother my child.)	
Independent Activities (child can do this alone)	
Assisted Activities (child will need help to do this)	
Special Pets, Friends, Family	
Child/Teen's Bedtime Weekday and Weekend	
Child/Teen's Bedtime Rituals and Routines	

Child/Teen Strengths

Youth Name _____ Youth Age _____

Source of Info (Youth, Caregiver, Teacher, Observation, etc.) _____

	1) Social	2) Academic	3) Athletic
Capacities	☐ Easily initiates relationships ☐ Keeps long-term relationships ☐ Good interpersonal boundaries ☐ Relates well with peers ☐ Relates well with adults ☐	☐ Good reading skills ☐ Good writing skills ☐ Good math skills ☐ Good verbal skills ☐ Good computer skills ☐	☐ Good at team sports (e.g. basketball, foot- ball, baseball) ☐ Good at independent or non-competitive sports (swimming, gymnastics, jogging, yoga, rock climbing…) ☐
Interests	☐ Wants to have friends ☐ Wants relationships with caring adults ☐ Wants to belong to peer groups, clubs ☐ Likes to help others ☐ Enjoys caring for animals ☐	☐ Enjoys reading ☐ Enjoys writing ☐ Enjoys math or science ☐ Enjoys computers ☐	☐ Wants to play team sports ☐ Wants to learn individual or non-competitive sports ☐
Resources	☐ Has close (pro-social) friend(s) ☐ Has access to adult mentor ☐ Has access to naturally occurring groups, clubs, volunteer work, opportunities etc. ☐	☐ Has access to opportunities to display, share, or enhance academic abilities ☐	☐ School offers athletics programs ☐ Neighborhood offers athletics programs ☐

	4) Artistic/Creative	5) Mechanical	6) Cultural/Spiritual
Capacities	☐ Talent in visual arts (drawing, painting, etc.) ☐ Talent in performing arts (singing, dancing, drama, music, etc.) ☐ Skills in domestic arts (cooking, sewing, etc.) ☐	☐ Able to assemble & disassemble bikes, appliances, computers… ☐ Skills in using tools for carpentry, woodworking… ☐ Skills in car maintenance or repair ☐	☐ Knowledge of own heritage ☐ Knowledge of spiritual belief system ☐ Practices cultural/ spiritual customs/rituals ☐
Interests	☐ Desires to develop talent in visual arts ☐ Desires to develop talent in performing arts ☐ Desires to develop talent in domestic arts ☐	☐ Enjoys fixing appliances, etc. ☐ Enjoys building, wood-working ☐ Enjoys working on cars or desires to learn mechanics ☐	☐ Likes to attend church or other place of worship ☐ Desires to learn about own heritage ☐ Desires to participate in cultural or spiritually oriented activities ☐
Resources	☐ School offers programs in type of art preferred ☐ Neighborhood offers programs in type of art preferred ☐	☐ School offers vocational program in mechanical area of interest/skill ☐ Has opportunity to serve as apprentice in mechanical area of choice ☐	☐ Connected to place of worship ☐ Has access to opportunities to participate in culturally oriented activities ☐

Other Strengths: _____

Completed By: _____ Date: _____

* You may be able to find other lists of strengths online. These charts were adapted from: Cox, K. (2008). A roadmap for building on youths' strengths. In E. J. Bruns & J. S. Walker (Eds.), The resource guide to wraparound. Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children's Mental Health.

Home Management

Other Documents That I Will Add to This Section:

- ☐ Pay stub with itemized wages, taxes and deductions
- ☐ Chore Chart
- ☐
- ☐

Where We Live

Our Current Address: _____

_____

_____

When we moved to this address: _____

Our Housing History

Address: _____

When we moved there: _____When we moved away: _____

Address: _____

When we moved there: _____When we moved away: _____

Address: _____

When we moved there: _____When we moved away: _____

Address: _____

When we moved there: _____When we moved away: _____

Funding Sources & Assistance

Job _____

How often do you get paid? _____

Funds per month $ _____

Job _____

How often do you get paid? _____

Funds per month $ _____

Other Funding Source _____

How often do you get paid? _____

Funds per month $ _____

Other Funding Source _____

How often do you get paid? _____

Funds per month $ _____

Assistance and Supports

Visit Bridges to Benefits to find out where to apply and what agencies can help you with the application process. http://mn.bridgetobenefits.org/ScreeningTool/ProgramDirectory

Cash Assistance--- Diversionary Work Program (DWP) or Minnesota Family Investment Program (MFIP)

Case Worker and Contact Info _____

Funds/Benefits per month $_____

Start Date _____ End Date _____

Child Care Assistance Program

Case Worker and Contact Info _____

Funds/Benefits per month $_____

My Co-Pay $_____

Start Date _____ End Date _____

Energy Assistance Program (EAP)

Case Worker and Contact Info _____

Funds/Benefits per month $_____

Start Date _____ End Date _____

Ramsey County Emergency Financial Assistance

Case Worker and Contact Info _____

Funds/Benefits per month $_____

Start Date _____ End Date _____

Rental Assistance (Section 8, Public & Indian Housing)

Case Worker and Contact Info _____

Funds/Benefits per month $_____

Start Date _____ End Date _____

Supplemental Nutrition Assistance Program (SNAP)--- Food EBT Card

Case Worker and Contact Info _____

Funds/Benefits per month $_____

Start Date _____ End Date _____

Supplemental Security Income (SSI)

Case Worker and Contact Info _____

Funds/Benefits per month $_____

Start Date _____ End Date _____

Women, Infants and Children (WIC)

Case Worker and Contact Info _____

Funds/Benefits per month $_____

Start Date _____ End Date _____

Other Assistance/Support _____

Case Worker and Contact Info _____

Funds/Benefits per month $_____

Start Date _____ End Date _____

Other Assistance/Support _____

Case Worker and Contact Info _____

Funds/Benefits per month $_____

Start Date _____ End Date _____

Other Assistance/Support _____

Case Worker and Contact Info _____

Funds/Benefits per month $_____

Start Date _____ End Date _____

Other Assistance/Support _____

Case Worker and Contact Info _____

Funds/Benefits per month $_____

Start Date _____ End Date _____

Monthly Income

Funding Source	How much?
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$
TOTAL MONTHLY INCOME	**$**

SAMPLE Income Chart	
Supplemental Security Income (SSI)	$ 600.00
SNAP (food stamps)	$ 150.00
Part-time job	$ 200.00
Total Monthly Income	**$ 950.00**

My Savings

Description	How Much?
	$
	$
	$
	$
	$

Monthly Living Expenses

Use this worksheet to track your "everyday" expenses. For 1 month, save receipts for everything you buy! If you don't get a receipt, then write a note to yourself about what you spent. Don't forget to look at the expenses on your credit card or debit card statements. At the end of the month, add it all up! Put an X in the column if the item is something you "need" or something you "want." Remember that we have some control over our "everyday" spending.

Description	Need	Want	How Much?
Beauty/Personal Maintenance (hair salon, make up, nails…)	☐	☐	$
Cleaning Supplies (mop, laundry detergent…)	☐	☐	$
Clothing	☐	☐	$
Eating out	☐	☐	$
Entertainment (cell phone apps, games, movies…)	☐	☐	$
Furniture and Household Items (lamp, vacuum cleaner)	☐	☐	$
Groceries	☐	☐	$
Maintenance (car repair, oil change, fixing a laptop…)	☐	☐	$
Medical (co-pays, over the counter medicines…)	☐	☐	$
Personal Care Items (toothpaste, diapers…)	☐	☐	$
School	☐	☐	$
Transportation (bus tickets, gasoline…)	☐	☐	$
	☐	☐	$
	☐	☐	$
	☐	☐	$
	☐	☐	$
	☐	☐	$
	☐	☐	$
	☐	☐	$
	☐	☐	$
	☐	☐	$
	☐	☐	$
TOTAL MONTHLY EXPENSES			$

Monthly Bills and Debt

Description	How Much?
Bundle—Internet, TV, Phone	$
Cell Phone	$
Credit Card #1 debt *	$
Credit Card #2 debt *	$
Internet	$
Phone (landline)	$
Rent or housing payment	$
Student Loans	$
TV	$
Utilities (Electricity)	$
Utilities (Gas)	$
	$
	$
	$
	$
	$
	$
	$
	$
Total Monthly Bills	$

Compared to our "everyday" living expenses, we have less control over our monthly bills and debts. These amounts tend to be a set amount every month.

* If you are carrying unpaid debt on your credit card, enter your average monthly payment on this Monthly Bills and Debts worksheet. (Example: I pay $100 every month to Visa.)

* If you use your credit card to make purchases each month, enter all of your monthly credit card purchases on the Monthly Expenses worksheet. (Example: In October, I used my credit card to purchase $40 in gasoline and $58 in groceries. So, I will add those purchases to my Monthly Expenses worksheet.)

Monthly Budget

Name of Month_____

Look at your Monthly Income and Savings to decide how much money you can spend. Try to plan for surprises (like a car repair.) Think about "Needs" versus "Wants". Try not to spend more than your Planned Monthly Income.

Planned Monthly Income (jobs, other income, and assistance/benefits) $ _____

At the beginning of the month, fill out "How I will Spend My Money" and "Planned Spending." At the end of the month, fill out "Actual Spending" and the worksheet on the next page.

How I Will Spend My Money (living expenses, bills, and debts)	**Planned Spending My Cash**	**Planned Spending Assistance/Benefits**	**Actual Spending Cash + Assistance**
Example: groceries	*$ 50.00*	*$ 300.00*	*$ 350.00*
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		
Totals	$	$	$

Monthly Budget Worksheet

Fill in this worksheet at the end of each month…

$ _____ Total Actual Monthly Income (jobs, other income & assistance/benefits)

\- $_____ Total Actual Spending (cash & assistance/benefits)

_____

$ _____ Total over or under budget for this month

If you are under budget → Yay! You can put your money in savings or spend it on something you have been wanting/needing.

If you are over budget → This means that you spent more that you have. You may need to borrow money, use your savings, take on extra hours at your job or maybe add on a "side hustle" like babysitting, rideshare driving, or car repair etc.

Savings

I Am Saving My Money For…

1. _____
2. _____
3. _____
4. _____
5. _____

Work/Volunteer History

Employer: _____

Job Title: _____

Date Started: _____ Date Ended: _____

Salary or Hourly pay: _____

Employer: _____

Job Title: _____

Date Started: _____ Date Ended: _____

Salary or Hourly pay: _____

Employer: _____

Job Title: _____

Date Started: _____ Date Ended: _____

Salary or Hourly pay: _____

Employer: _____

Job Title: _____

Date Started: _____ Date Ended: _____

Salary or Hourly pay: _____

Employer: _____

Job Title: _____

Date Started: _____ Date Ended: _____

Salary or Hourly pay: _____

Weekly Meal Plan

M

T

W

TH

F

S

SU

Grocery List

Wellbeing

Other Documents That I Could Add to This Section:

- ☐ Nutrition Log
- ☐ List of Community Resources
- ☐
- ☐

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- D2 ű2 ŎKdzNJŎK 2NJ ŦI·ƛűK ƎNJ2dzLJ
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[I·dzƎKűŜNJπ LŦ è2dz Ř2yűú ŦŜŜf fƛ]Ŝ fI·dzƎKƛyƎXŦI·]Ŝ ƛű¢ {ŎƛŜyŎŜ ăI·èă ûKI·ű ŜØŜy˙ŦI·]Ŝ fI·dzƎKƛyƎ ØƛffƛY˙LJNJ2ØŜ KŜI·fűK I·yŘ NJŜŘdzŎŜ ăúNJŜăă¢ LűΩă ûNJdzŜH D22ƎfŜ ɑfI·dzƎKűŜNJ è2ƎI·ɛ

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Calm Down Toolkit

A Calm Down Toolkit is full of self-care items to distract and self-soothe during times of stress or distress. Make one for yourself and one for your child/teen! Your kit could be a box or a bag. Get creative- you could even decorate your kit!

- Cozy socks
- Soft blanket or weighted blanket
- Stuffed animal
- Noise canceling headphones
- Coloring book, crayons or colored pencils
- Hobby or craft item, scratch art
- Puzzles/brain teasers
- Book or audiobook, movie or music
- A protein snack
- A drink with electrolytes
- Herbal tea bags or cocoa
- Play dough
- Stress ball, fidgets, pipe cleaners, spinning top
- Chewing gum, lollipops, chew toy/ chew necklace
- Harmonica
- Calm down jar, snow globe, light up toys
- Hand lotion, bubble bath, face mask, or nail polish
- Scented candle, essential oils, or scratch and sniff stickers
- Hot or cold therapy packs
- Mini massager
- Yoga poses/ yoga activity cards
- Stretch resistance bands or other small exercise equipment
- Bubble wrap – pop your stress away!
- Journal or notebook and pen
- Photos or mini photo album
- Kleenex- its ok to have a good cry!
- Uplifting messages from family or friends
- Funny or uplifting sayings, quotes or poems
- Therapy worksheets or a self-help article.
- A letter to self – to comfort and guide yourself in times of trouble.

Use an app like the **Virtual Hope Box** which includes sections like: Distract Me, Inspire Me, Relax Me, and Coping Tools. Do fun activities and use mindfulness tools. Put photos, videos, recorded messages from loved ones, inspirational quotes, and music in your Hope Box.

Food, Energy, Exercise, Sleep, Weight

Name_____ **Dates** ____/_____/_____ **to** ____/____/____

	Food and Nutrition	**Energy 0-5** (low to high)	**Exercise or Physical Activity**	**Sleep** (10:30 pm to 6:30 am)	**Weight**
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
Sunday					

Food, Energy, Exercise, Sleep, Weight

Name_____ **Dates** ____/_____/_____ **to** ____/____/____

	Food and Nutrition	**Energy 0-5** (low to high)	**Exercise or Physical Activity**	**Sleep** (10:30 pm to 6:30 am)	**Weight**
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
Sunday					

Food, Energy, Exercise, Sleep, Weight

Name_____ **Dates** ____/_____/_____ **to** ____/____/____

	Food and Nutrition	**Energy 0-5** (low to high)	**Exercise or Physical Activity**	**Sleep** (10:30 pm to 6:30 am)	**Weight**
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
Sunday					