



Social Services Administration One-on-One Services Program Request

Instructions: The Local Department of Social Services (LDSS) is required to complete this form to request One-on-One services for a youth placed in Out-of-Home Care Placement. **All LDSS and youth information including assigned caseworker, medications, placement/living arrangement, services, and etc. entered on this form must align with CJAMS.**

Check one of the boxes: Initial Request Extension/Modification Request

Request Date: _____

Did service start before the request was submitted? Yes No

For Extension/Modification Request, provide date of initial One-on-One request: _____

Local Department of Social Services (LDSS): _____

Youth's Name:

Age: DOB:

CJAMS PID#:

Gender Identity:

Current Placement Structure, Living Arrangement:

Address of Placement :

LDSS Staff

Case Manager Name, Email Address, and Contact Number: _____

One-on-One Local Project Manager: _____

Case Review: Team Meeting Date: _____

Case Manager Attended: Yes No

Service Vendor Information

Program Name: _____

Address: _____

Services Available: _____ Youth's Service Region: _____

Date Service Started with Youth: _____

Clinical Manager Name, Email Address, and Contact Number:

Youth Current and Past Information

Outpatient/Inpatient Treatment (include Psychiatric Rehabilitation Program/PRP)? No Yes, provide brief description of services during the past year (diagnosis; outpatient; inpatient):

Specialized Education Services? No Yes, provide brief description (e.g., are needs or behaviors in school setting exhibited outside of school setting; Individualized Education Program/IEP; Behavior Intervention Plan/BIP; or a 504 plan):

Hospitalizations within the past 6 months (medical; psychiatric)? No Yes, brief description of reason for hospitalization:

Psychotropic Medication? No Yes, list medications and youth's compliance with medication:

Presenting Challenges, Behaviors? Check all that apply and description must be entered if "Other" selected.

<input type="checkbox"/> Suicidal Ideation <input type="checkbox"/> Intermittent <input type="checkbox"/> Constant	<input type="checkbox"/> Homicidal Ideation <input type="checkbox"/> Intermittent <input type="checkbox"/> Constant
<input type="checkbox"/> Suicidal threats <input type="checkbox"/> Intermittent <input type="checkbox"/> Constant	<input type="checkbox"/> Homicidal threats <input type="checkbox"/> Intermittent <input type="checkbox"/> Constant
<input type="checkbox"/> Elopement, wandering <input type="checkbox"/> Daily <input type="checkbox"/> Past 7days <input type="checkbox"/> Past 14days	<input type="checkbox"/> Verbal threats <input type="checkbox"/> Daily <input type="checkbox"/> Past 7days <input type="checkbox"/> Past 14days
<input type="checkbox"/> Rage reaction <input type="checkbox"/> Daily <input type="checkbox"/> Past 7days <input type="checkbox"/> Past 14days	<input type="checkbox"/> Aggression to peers or adults <input type="checkbox"/> Daily <input type="checkbox"/> Past 7days <input type="checkbox"/> Past 14days
<input type="checkbox"/> Seeks out weapons or other harmful objects <input type="checkbox"/> Daily <input type="checkbox"/> Past 7days <input type="checkbox"/> Past 14days	<input type="checkbox"/> Physical aggression <input type="checkbox"/> Daily <input type="checkbox"/> Past 7days <input type="checkbox"/> Past 14days
<input type="checkbox"/> History of various challenging behaviors*	<input type="checkbox"/> Difficulty with activities of daily living* (ADLs)
<input type="checkbox"/> Other: Text field <input type="checkbox"/> Daily <input type="checkbox"/> Past 7days <input type="checkbox"/> Past 14days	<input type="checkbox"/> Other: Text field <input type="checkbox"/> Daily <input type="checkbox"/> Past 7days <input type="checkbox"/> Past 14days

***Provide brief description** (frequency of behaviors, any intervention or approaches utilized to manage, physical/medical condition):

Juvenile services involvement? No Yes, provide brief description e.g. violent offense; non-violent offense (vandalism; shoplifting; possession of controlled dangerous substance/CDS); detainments:

Request: Select one and provide all information requested

Initial

Initial request for One-on-One support: _____

Intensity: _____

Frequency: _____ days per week, _____ hours per day

Service date (30 days of service**): _____ to _____

Costs (unit and total cost for 30 days of service**): _____

***Actual or anticipated service start date with the youth*

Extension/Modification

1. What specific interventions or strategies have been implemented to address the identified challenges/behaviors and to increase adaptive functioning (include date of most current treatment plan)?

2. Have any interruptions or gaps in service delivery or changes in the youth's needs contributed to the request for an extension or modification? No Yes, explain (be specific regarding the extension or modification reason)

3. Are there services currently being considered that could meet the youth's needs when One-on-One support ends (please explain)?

Continuation request for One-on-One support: _____

Intensity: _____

Frequency: _____ days per week, _____ hours per day

Service dates (30 days of service): _____ to _____

Costs (unit and total cost for 30 days of service): _____

APPROVAL***

LDSS Assistant Director (or designee) Name: _____

Signature _____ Date: _____

SSA Project Manager Name: _____

Signature _____ Date: _____

Effective Date: _____

DENIAL Reason: _____

SSA Project Manager Name: _____

Signature _____ Date: _____

*****A treatment plan from the service vendor must be submitted by 4:00 PM on the 6th day initial service provided. Any treatment plan updates must be maintained in the youth's file by the service vendor and CJAMS for the LDSS.**