Pennsylvania Infant/Early Childhood Mental Health Consultation Program
Request for IECMHC Services- Child Specific

*Return to Completed Form to PAIECMH@pakeys.org or fax 717-213-3749

Date **Case ID** (assigned by consultant)

Child's Name: **Date of Birth**

Child Information

Gender: □ Male □ Female Is the Child of Hispanic or Latino descent? □ Yes □ No □ Unspecified

Race: □ American Indian/Alaskan Native □ Asian □ Black/African American □ Hispanic
□ White/Caucasian □ Multi-Racial □ Pacific Islander □ Unknown

What is the child's primary language? Secondary Language?

Child care services are funded through: □ Child Care Works □ PHL PreK □ PA Pre-K Counts □ IT Contracted Slots □ NA
What other services/systems are involved on behalf of this child? □ EI 0-3 □ EI 3-5 □ Child Welfare
□ Child Mental Health □ Case Management Services □ Head Start □ Home Visiting □ PA Pre-K Counts
□ Rapid Response □ NA
Recent Referrals Made (if any, i.e. EI, MH):

Does the child have an IFSP or IEP? □ Yes □ No **Do you have a copy of the IEP/IFSP?** □ Yes □ No

Early Learning Program Information

Program Name: **MPI #**

Director Name: **Program Type:** ☐ Center ☐ Family ☐ Group

Address:

Phone: **Fax:** **Email:**

County:

STAR Level: ☐STAR 1 ☐ STAR 2 ☐ STAR 3 ☐ STAR 4 ☐ Accredited ☐ NA
Early Learning Resource Center (ELRC) Quality Coach (if known):

Classroom Information (for referred child)

1. **Teacher Name:** **PD Registry ID #:**

   Role: □ Lead □ Assistant □ Other:
   Education Level: □ HS □ CDA □ AA □ BA/ BS □ Masters □ Non-related degree
2. **Teacher Name:** **PD Registry ID #**

   Role: □ Lead □ Assistant □ Other:
   Education Level: □ HS □ CDA □ AA □ BA/ BS □ Masters □ Non-related degree
3. **Teacher Name:** **PD Registry ID #**

   Role: □ Lead □ Assistant □ Other:
   Education Level: □ HS □ CDA □ AA □ BA/ BS □ Masters □ Non-related degree

Classroom Name: **Children in classroom (max # allowed):**

Age Range (in classroom):

TO BE COMPLETED BY CLASSROOM STAFF

Please describe your concern(s), including what the child's behavior is telling you about their needs and experience of the early learning environment.

Have you recently administered a developmental/SE screening? □ Yes □ No (For example: ASQ-3® or ASQ:SE2®)

Please describe any screening or assessment results related to your concern(s).

Please describe communication you have had with the family/guardian about your concern(s).

Please check the area that MOST CLOSELY matches your concerns at this time:

□ **Attachment** (ex. does not seek familiar adults for comfort, displays very little emotion or is emotionally independent, wariness/on-guard, fearfulness, rejection or avoidance of touch)
□ **Self-regulation** (ex. tantrums, inconsolable "fussiness" or irritability, incessant crying, poor impulse control, inability to comfort/calm self, and limited coping skills with emotions/stress)
□ **Communication** (ex. limited or no communication (including non-verbal), lack of language that is considered developmentally appropriate)
□ **Aggression** (ex. any attempt or physical contact with another person in the form of hitting, kicking, biting, choking, pushing, poking, pulling hair, spitting, throwing things with directional intent)
□ **Interaction** (ex. withdrawn, difficulty playing, sharing or exchanging materials with others, difficulty take turns; little interest in sights/sounds/touch)

Please describe what you have tried to address your concern(s):

The statements below describe how some teachers might feel about a child in their classroom. Please indicate how strongly you agree with each statement based on the child you are referring for IECMHC. Remember there are no right or wrong answers, so please give your honest opinion and feelings. (Gilliam & Reyes, 2016)

Preschool Expulsion Risk Measure	Strongly Disagree (1)	Somewhat Disagree (2)	Neither Agree nor Disagree (3)	Somewhat Agree (4)	Strongly Agree (5)
This child's classroom behaviors interfere with my ability to teach effectively.					
This child's classroom behaviors interfere with my ability to maintain control of the class.					
This child's classroom behaviors interfere with other children's opportunity to learn.					
This child's classroom behaviors may result in someone getting hurt or property being damaged.					
This child might do something for which I would be held responsible, reflecting poorly upon my teaching skills.					
Other parents complain about this child's classroom behaviors.					
This child's classroom behaviors are not likely to improve significantly.					
There is little that I or anyone else can do to significantly improve this child's behavior.					
This child's parents will not be much help in improving this child's behavior.					
My job as a teacher would be easier if this child were not in my classroom.					
My job is more stressful because of this child's behaviors.					
Some mornings I find myself hoping that this child will be absent from my classroom.					

Infant/Early Childhood Mental Health Consultation Program
Parent/Guardian and Childcare Program Agreement

Child Name: Date of Birth:

Parent/Guardian Name:	*Parent/Guardian Name:
Address	Address
Email	Email
Phone	Phone
Relationship to Child	Relationship to Child

- I authorize the Infant/Early Childhood Mental Health Consultation Program (IECMHC) to provide consultation services to myself and my child's child care program which include the following:
    - Observation of the child care environment and consultation to myself and my child's teachers to support my child's social-emotional development and improve my child's experiences in the child care environment.
    - Support implementation of or administer universal screening to determine my child's developmental strengths and areas of risk, where applicable.
- I understand that the Consultant may provide me with information about child-related concerns and resources within my community that could be helpful.
- I understand that any information about my child/family will be kept confidential and not be shared without written permission.
- I agree that IECMHC may collect a variety of data about me and my child(ren) and store these data on a secure database. Only professional staff authorized by the Pennsylvania Key will have access to these data. All data will be kept confidential, and aggregate data may be used in evaluation or research reports to help improve the IECMHC services.
- I understand that IECMHC staff are mandated reporters for child abuse and child care licensing violations.
- I understand that I will be invited to participate in team meetings and collaborative action plan development.
- I understand that consultation is suggestive in nature and that I remain responsible for the decisions I make on behalf of my child/family. The consultative suggestions shared for consideration are not a state mandate or required.
- I understand that participation in IECMHC is voluntary by both child/family and the child care program. Any party may discontinue participation at any time, preferably by notifying the consultant directly.

Parent/Guardian Signature Date:

Parent/Guardian Signature Date:

Second Parent/Guardian NOT REQUIRED, but provided as an option to include

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Childcare Program:	Director Name:
Address	County
Email	Phone

I authorize the Infant Early Childhood Mental Health Consultation Program (IECMHC) to provide consultation services in my child care program and as Program Director/Administrator:

- I will ensure the Consultant has access to classroom visits, observations, and time to meet with myself and classroom staff to discuss policies/practices that support equity, SE development and the relational health of children in our care.
- I will ensure that myself and classroom staff are available to participate in ongoing communication with consultant and family, team meetings, assist with collecting documentation/outcome tools and support the implementation of team-developed action steps and recommendations.
- I agree to keep all information reviewed, shared and received confidential.
- I acknowledge that IECMHC staff are mandated reporters for child abuse and child care licensing violations.
- I understand that consultation is suggestive in nature and that I remain responsible – ethically and legally – for the decisions I make within the child care environment. The consultative suggestions shared for consideration are not a state mandate or required.
- I understand that participation in IECMHC is voluntary by both child/family and the child care program. Any party may discontinue participation at any time, preferably by notifying the consultant directly.

Program Director Signature: Date

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Programa de consulta de salud mental para bebés/primera infancia
Acuerdo del padre/madre/tutor legal y del programa de cuidado niños

Nombre del niño: Fecha de nacimiento:

Nombre del padre/madre/tutor:	*Nombre del padre/madre/tutor:
Dirección	Dirección
Correo electrónico	Correo electrónico
Teléfono	Teléfono
Relación con el niño	Relación con el niño

- Autorizo al programa de consultas de salud mental para bebés/primera infancia (Infant/Early Childhood Mental Health Consultation Program, IECMHC) a proporcionar servicios de consulta a mí y al programa de cuidado infantil de mi hijo, que incluyen lo siguiente:
    - Observación del entorno de cuidado infantil y consulta para mí y para los maestros de mi hijo para apoyar el desarrollo socioemocional de mi hijo y mejorar sus experiencias en el entorno de cuidado infantil.
    - Apoyar la implementación o administrar la detección universal para determinar las fortalezas y las áreas de riesgo de desarrollo de mi hijo, cuando corresponda.
- Comprendo que el Consultor puede proporcionarme información sobre inquietudes y recursos relacionados con los niños dentro de mi comunidad que podrían ser útiles.
- Comprendo que se mantendrá la confidencialidad de cualquier información sobre mi hijo/familia y que no se compartirá sin un permiso por escrito.
- Acepto que IECMHC pueda recopilar una variedad de datos sobre mí y mi(s) hijo(s) y almacenar estos datos en una base de datos segura. Solo el personal profesional autorizado por Pennsylvania Key tendrá acceso a estos datos. Se mantendrá la confidencialidad de todos los datos. Los datos agregados pueden usarse en informes de evaluación o investigación para ayudar a mejorar los servicios de IECMHC.
- Comprendo que el personal de IECMHC está obligado a informar cualquier abuso infantil o violación a la licencia de cuidado infantil.
- Comprendo que se me invitará a participar en reuniones de equipo y en el desarrollo de un plan de acción colaborativo.
- Comprendo que la consulta es de naturaleza sugestiva y que sigo siendo responsable de las decisiones que tome en nombre de mi hijo/familia. Las sugerencias consultivas compartidas para su consideración no son un mandato o requisito estatal.
- Comprendo que la participación en IECMHC es voluntaria tanto por parte del niño/familia como del programa de cuidado infantil. Cualquiera de las partes puede interrumpir la participación en cualquier momento, preferentemente mediante notificación directa al consultor.

Firma de padre/madre/tutor Fecha:

Firma de padre/madre/tutor Fecha:

Segundo padre/madre/tutor NO REQUERIDO, pero se proporciona como una opción para incluir

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Programa de cuidado infantil:	Nombre del director:
Dirección	Condado
Correo electrónico	Teléfono

Autorizo al programa de consultas de salud mental para bebés/primera infancia (IECMHC) a proporcionar servicios de consulta en mi programa de cuidado infantil y como director/administrador del programa haré lo siguiente:

- Me aseguraré de que el Consultor tenga acceso a visitas al aula, observaciones y tiempo para reunirse conmigo y con el personal del aula para analizar las políticas/prácticas que apoyan la equidad, el desarrollo socioemocional y la salud relacional de los niños bajo nuestro cuidado.
- Me aseguraré de que el personal del aula y yo estemos disponibles para participar en la comunicación continua con el consultor y la familia y en las reuniones de equipo, ayudaré con la recopilación de herramientas de documentación/resultados y apoyaré la implementación de medidas y recomendaciones desarrolladas por el equipo.
- Acepto mantener la confidencialidad de toda la información revisada, compartida y recibida.
- Comprendo que el personal de IECMHC está obligado a informar cualquier abuso infantil o violación a la licencia de cuidado infantil.
- Comprendo que la consulta es de naturaleza sugestiva y que sigo siendo responsable, ética y legalmente, de las decisiones que tome dentro del entorno de cuidado infantil. Las sugerencias consultivas compartidas para su consideración no son un mandato o requisito estatal.
- Comprendo que la participación en IECMHC es voluntaria tanto por parte del niño/familia como del programa de cuidado infantil. Cualquiera de las partes puede interrumpir la participación en cualquier momento, preferentemente mediante notificación directa al consultor.

Firma del director del programa: Fecha

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