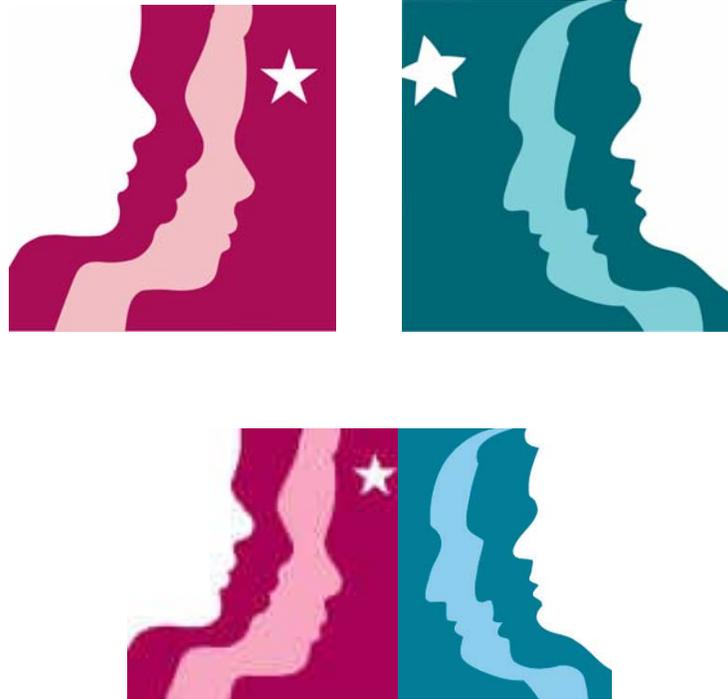


Community Resource Coordination Groups of Texas (CRCG)

Data Submission Guide

For Local Community Resource Coordination Groups:
An Instructional Guidebook to Accompany the CRCG Data
Submission Forms



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2007

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Introduction

The Community Resource Coordination Groups of Texas (CRCGs) provide a mechanism that allows local public agencies and private organizations to work together to assist individuals who have multiple agency needs. Local CRCGs are county-based, with some CRCGs serving multiple counties. CRCGs that serve children and youth are available for every county in Texas. Additionally, CRCGs for Adults (CRCGAs) and/or CRCGs that serve any age, known as CRCGs for Families (CRCGFs) are developing across the state. This collaborative approach works well for agencies, organizations, and the persons who are served through the CRCG process. The efficiency and success of this approach have led increasing numbers of counties and communities to expand their CRCG assistance to address the needs of all individuals and families within their jurisdictions.

The Community Resource Coordination Group process is simple and straightforward. An individual or a family may come to the local CRCG for individual service planning by any one of several routes. The person may be working with an assigned caseworker and a specific human service agency and find that additional assistance is needed. That person may either have multiple needs that fall under the missions of one or more additional agencies, or have difficulty accessing a specific service because they do not meet the eligibility guidelines. It could be a single individual or a whole family with a complex list of issues that comes to the CRCG for service planning (i.e., be “staffed” by the CRCG). Occasionally a family member may learn the time and location of regular CRCG meetings and request CRCG service planning with no prior involvement from any agency. The important point is that members of the local CRCG become aware of an individual or family in their community whose needs are not being met and help to provide comprehensive service planning to identify and access needed services and supports.

The purpose of this manual is to provide simple, clear instructions to assist in the collection and reporting of CRCG service plan data. The Office of Program Coordination for Children and Youth is also available to provide assistance with this process.

Contact the Office of Program Coordination for Children & Youth:

Phone: (512) 424-6963

Mail: Texas Health and Human Services Commission
Office of Program Coordination for Children and Youth

MC: BH4100

P.O. Box 13247

Austin, Texas 78711

Fax: (512) 424-6591

Email: crcg@hhsc.state.tx.us

CRCG Meetings & Data Collection

CRCG meetings may have two parts. The first part, and main reason for the meeting, is the development of an individual service plan, known as a “staffing.” The intended purpose of the CRCG meeting is to develop a CRCG service plan *in partnership* with the referred individual and/or family; therefore, they should be invited to the meeting and reasonable efforts made to assist their participation. For example, the time or place of the meeting might be moved to be more convenient for the individual and/or family.

The second part of the CRCG meeting may include the sharing of agency or community organization news, such as the development of new programs that might become useful resources to the community, new acquisition of grant funds, and new equipment or other new materials that might benefit the community.

Each individual or family who comes to the CRCG for service planning assistance receives the group’s **confidential**, focused attention. While the information sharing, or business portion of each meeting is open to visitors and outside speakers, the staffing portion of the meeting is closed, and includes only CRCG members, additional social service providers specific to the family being staffed, and the individual or family members whose requests/issues are to be addressed.

During each staffing, the CRCG keeps a written record of the proceedings. That record includes an attendance roster of agencies, organizations, family members and others present for the discussion. Basic demographic information is collected for each individual or family served. The issues and needs expressed by the individual or family are documented in order that the CRCG can track its progress and respond to those issues and needs in a timely manner. Information from that record is entered into a cumulative, statewide data collection system. Data sent to the State Office does **not** include any client-identifying information and is limited to meeting attendance, general demographic facts, and general indication of needs and issues to be addressed. This data collection allows the State Office to respond to local CRCGs, local community leaders, and Texas legislators regarding the extent and type of service needs in any county.

Note: DO NOT submit any confidential, client-identifying information regarding the person or family being served by the local CRCG. Information that should NOT BE SUBMITTED and should remain confidential includes: the person’s name, address, phone number, social security number, and any other information that would enable an outside observer to identify the specific person being served.

CRCG Meeting Attendees

Legislation that authorizes CRCGs mandates participating state agencies' executive directors sign a Memorandum of Understanding (MOU) that clearly outlines the roles and obligations of CRCG Member Agencies. The CRCG Meeting Information form includes all agencies that have signed the MOU, as well as spaces for other members' participation.

In order to provide the most complete, comprehensive individual service plan, the local CRCG may also wish to invite the participation of private organizations, faith-based groups, and other individuals who can provide additional resources. Additionally, each CRCG is required to include a standing member who can serve as a parent or consumer representative. This standing member is in addition to the consumer, family member, or care provider of the person being served.

All attendees should be indicated on the **CRCG Meeting Information** form.

Data Submission Format Choices

The Office of Program Coordination for Children and Youth provides two primary formats for the submission of CRCG service plan data:

- Web-based data entry or
- Paper forms submitted to the State Office via mail, e-mail, or fax.

Both formats provide similar options and follow the same data entry sequence. Local CRCGs are encouraged to use the web-based data collection system. Each data submission session is an independent function. Therefore, any CRCG may choose either submission format each time data is submitted to the State Office.

The data submission sequence includes:

- **CRCG Meeting Information** - A form detailing the CRCG name and type, meeting location, meeting date, and attendees. It is completed only once for each meeting.
- **Initial Service Plan (Staffing) Form** - A separate form is completed for each initial staffing case developed at the CRCG meeting.
- **Follow-up Form** - A form is completed for each follow-up staffing conducted at the CRCG meeting for a previously developed initial service plan.

Completing the Forms

Step 1 – Choose the data-reporting format that fits your CRCG reporting needs. See Section 1 (page 6) for detailed instructions for online forms, and Section 2 (page 20) for detailed instructions for paper forms. See Appendices A, B, and C for copies of the paper forms.

Step 2 – Complete the **CRCG Meeting Information** form.

Step 3 – Complete an **Initial Service Plan (Staffing) Form** for each individual service plan, or “staffing,” created at the monthly meeting. A single individual service plan is completed whether the plan pertains to one individual or multiple family members.

Step 4 – If the meeting agenda includes follow-up information for any previously developed individual service plans, complete a **Follow-up Form** for each follow-up to an individual service plan.

Step 5 – Review your entries, make any corrections or additions necessary and make a copy for your CRCG files.

Step 6 – Submit the data to the Office of Program Coordination for Children and Youth.

- Submit through the online system at:
http://www.hhsc.state.tx.us/crcg/StaffingForm2007/Staffing_Login.asp
- Submit forms via e-mail to crcg@hhsc.state.tx.us
- Submit paper reports via fax: (512) 424-6591, or by mail to:

Texas Health and Human Services Commission
Office of Program Coordination for Children and Youth
MC: BH4100
P.O. Box 13247
Austin, Texas 78711

Phone: (512) 424-6963

Step 7 – Local CRCG Data Report - You may request periodic data reports that reflect the data submission from the counties served by your CRCG. Contact the State Office to request customized data reports. See example of a local report, Appendix D.

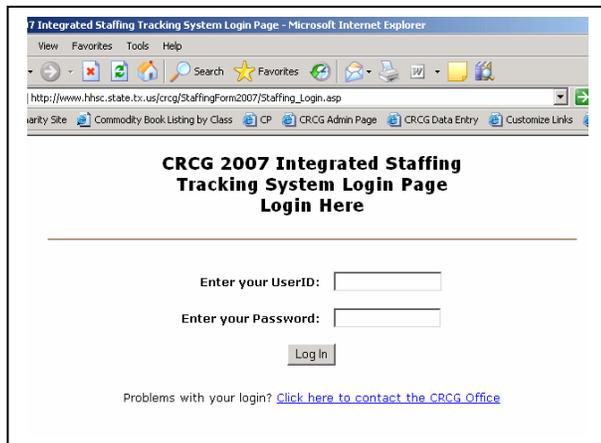
Section 1 - Online Data Collection

Getting Started:

CRCG website: <http://www.hhsc.state.tx.us/crcg/crcg.htm>

Bookmark this site (or save to your Favorites list) for easy access.

From the CRCG Home page above, click on CRCG Data , then click the link **Enter CRCG Data**. Click **Submit CY 2007 data online** to go to the login page. (You may also want to bookmark this page for easy return.)



Please contact the State CRCG Office at (512) 424-6963 to obtain userID and password.

Technical Requirements:

- Internet Connection
- Netscape 4.76 or Internet Explorer 5+ (with javascript enabled for the login screen)

If you have any difficulty with login, contact the State Office – (512) 424-6963.

Integrated Staffing Forms 'Home' Page – From the Data Entry home page, you may enter data by selecting from the choices below:

- Enter a 2007 Monthly Meeting
- Enter 2007 Initial Staffings
- Enter Follow-ups

We have also provided additional links on the Integrated Staffing Home page to retrieve Monthly Meetings, Initial Staffings, and Follow-Ups directly from the database. You may find it convenient to be able to access the database to review and/or print information previously submitted.

- Find a Monthly Meeting for review/printing
- Find an Initial Staffing form for review/printing
- Find a Follow-up for review/printing

If you find that information you have submitted is incomplete or inaccurate, contact the State Office at (512) 424-6963 to make any changes. ***You cannot edit any information once it has been submitted to the database. Please do not re-enter data as this creates a duplicate entry, thereby skewing data results.***

CRCG MEETING INFORMATION – ONLINE SYSTEM

- 1) **Important:** All individual service plans and subsequent follow-ups are connected to a computer-generated monthly meeting ID number; therefore, it is very important to enter the CRCG meeting information *first*.
- 2) Select the link: **Enter a 2007 Monthly Meeting.**
- 3) Enter the name of your CRCG. If your CRCG is simply known by the names of the counties it serves, enter that information.
- 4) Select the name of the county where the meeting was **held**. NOTE: This is the county under which all staffings completed at this meeting will be recorded.
- 5) Select the type of CRCG. The choices include: CRCG (for Children and Youth), CRCGA (for Adults), and CRCGF (for Families). Please note that this does NOT reflect the age of the person(s) for whom individual service plans are being completed.
- 6) Type in the month, day and year of the meeting. It must be in the mm/dd/yyyy (i.e., 01/01/2007) format or the system will not allow you to go any further.

2007 CRCG Meeting Information

Complete this page only **once** for the entire CRCG meeting. This information may cover more than one staffing.

Name of CRCG Blooming County TEST	County where meeting was held ANDERSON
CRCG Type Family	Date of Meeting: (mm/dd/yyyy) 01/01/2007

Attendance: identify each agency, contractor, group or individual attending the CRCG meeting:

- 7) Indicate meeting attendance by clicking the box next to the agencies/areas of all meeting attendees. For any agencies being considered as “Other,” please type in the name of the organization. (Note: The full agency names are supplied at the bottom of this form.) If you find that you need to completely redo the information, click the **Reset** button at the bottom to clear all information.

DFPS <input type="checkbox"/> CPS <input type="checkbox"/> APS <input type="checkbox"/> PEI	DARS <input checked="" type="checkbox"/> Rehabilitation <input type="checkbox"/> Blind & Visually Impaired <input type="checkbox"/> Deaf & Hard of Hearing <input checked="" type="checkbox"/> ECI	DSHS <input type="checkbox"/> MH Center <input checked="" type="checkbox"/> Substance Abuse Sub-Contractor or Council <input checked="" type="checkbox"/> CSHCN	DADS <input type="checkbox"/> MRA/MH Center <input type="checkbox"/> Nursing Home <input type="checkbox"/> AAA <input type="checkbox"/> Assisted Living Facility <input checked="" type="checkbox"/> ICF/MR <input type="checkbox"/> Other DADS
TDHCA <input type="checkbox"/> Community Action Agency <input type="checkbox"/> Housing Authority	EDUCATION <input checked="" type="checkbox"/> ESC <input type="checkbox"/> ISD	WORKFORCE <input type="checkbox"/> Workforce Agency	JUVENILE JUSTICE <input checked="" type="checkbox"/> TYC <input type="checkbox"/> JPD <input type="checkbox"/> TCOOMMI (youth)
CRIMINAL JUSTICE/TDCJ <input type="checkbox"/> Adult Probation <input type="checkbox"/> Adult Parole <input type="checkbox"/> TCOOMMI (adult)		PRIVATE ORGANIZATION <input type="checkbox"/> Faith-Based <input type="checkbox"/> Non-Profit (Business, Individuals, etc.) <input type="checkbox"/> For-Profit (Business, Individuals, etc.) <input type="checkbox"/> Foundations	
<input checked="" type="checkbox"/> Advocacy Organization	<input type="checkbox"/> Texas I&R 2-1-1	<input type="checkbox"/> Standing Team Member (Parent, Family, Consumer, Caregiver)	
<input type="checkbox"/> Other: <input style="width: 100%;" type="text"/>			

- 8) When all information has been entered, click on the  button. You will receive a summary that you should check for accuracy. Click the  button on your browser to go back to the previous page to add or correct information. If the information is accurate, print the page for your records and click on the  button a *second* time. Your data is NOT submitted to the system until you have clicked  from *both* screens.

2007 CRCG Meeting Information Review

CRCG Name: **Blooming County TEST**
 CRCG County: **ANDERSON**
 CRCG Type: **Family** Date of Monthly Meeting: **01/01/2007**

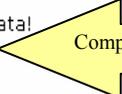
Attendees		
DARS_Rehab	DARS_ECI	DSHS_Substance_Abuse
DSHS_CSHCN	DADS_ICFMR	ED_ESC
JJ_TYC	Advocacy_Org	

Please review this information. If any information is in error, return to the 2007 Monthly Meeting Information page by clicking [here](#), or click on the 'back' button on your browser. If this information is accurate, [print this page](#) for your records and click on the 'Submit' Button below to send the data to the CRCG Staffing Information database.

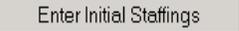


- 9) Once the CRCG Meeting Information is submitted to the system, the computer assigns a monthly staffing data ID number for that date's meeting. This is your reference for all initial service plans (staffings) generated for that date and any subsequent follow-ups for these initial service plans. *Print this page for future reference.* You will need the computer-generated Monthly Staffing Data ID to easily locate information submitted for that meeting at a later date.

Thank you for submitting your 2007 Monthly Staffing data!
 Your Monthly Staffing Data ID for **1/1/2007** is **3082**.

 Computer-generated Monthly Meeting ID #

The Monthly ID number is your reference for all Initial Staffings and Follow-Ups generated in a monthly staffing. You should [print this page](#) for future reference when looking up Initial Staffings and Follow-Ups for this Monthly Meeting.



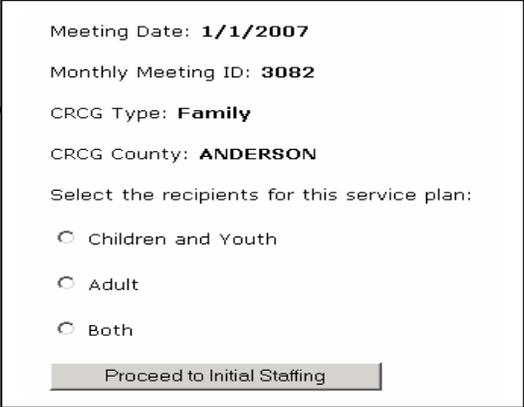
[Staffing Forms home page](#)

INITIAL SERVICE PLAN (STAFFING) – ONLINE SYSTEM

Submission of the **CRCG Meeting Information** form will provide easy access to a new **Initial Staffing Form** by clicking on the  button.

- 1) The first screen for the Initial Service Plan form states the meeting date, the monthly meeting ID number, the CRCG Type, and county that corresponds with the CRCG Meeting Information that was just entered.

Mtg Info



Meeting Date: **1/1/2007**
Monthly Meeting ID: **3082**
CRCG Type: **Family**
CRCG County: **ANDERSON**
Select the recipients for this service plan:
 Children and Youth
 Adult
 Both

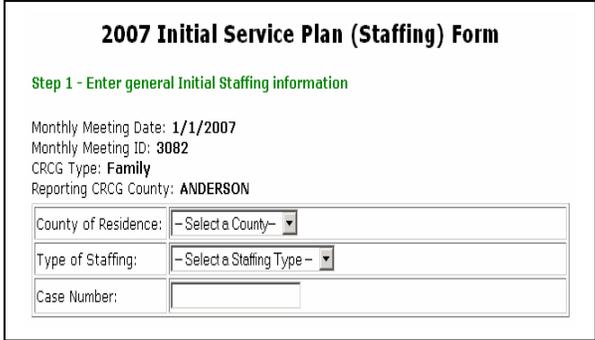

- 2) **Recipient(s):** The recipient(s) for a service plan include the referred individual and anyone else in the family for whom the service plan identifies a service or resource. Your choices include Children and Youth, Adult, or Both. Regardless of the type of CRCG: if the recipient is a child/youth, select *Children and Youth*; if the recipient is an adult, select *Adult*; and if there is a child/youth recipient **as well as** an adult (meaning there are two recipients), select *Both*. When you have selected the recipient(s), click on the  button. (This answer generates the questions/screens in #11 below.)

- 3) The **Initial Service Plan (Staffing)** form automatically displays the Meeting Date, Meeting ID number, CRCG Type, and Reporting County (entered from the CRCG Meeting Information form). Complete each section of the form.

- 4) **County of Residence:** Select the County of Residence (permanent address) for the referred individual. (This is not always the same as the CRCG county.)

- 5) **Type of Staffing:** Select the type of Staffing that is being documented.

- a) Full Staffing (Service plan developed at a regular CRCG meeting)
- b) Emergency Staffing (Individual is in crisis and needs immediate assistance – selected members may develop the plan.) This includes staffings completed via phone.
- c) Resource/Referral Staffing (Discussion for the purpose of identifying one or more resources to which an individual or a member agency may apply for assistance). This also includes staffings completed via phone.



2007 Initial Service Plan (Staffing) Form

Step 1 - Enter general Initial Staffing information

Monthly Meeting Date: 1/1/2007
Monthly Meeting ID: 3082
CRCG Type: Family
Reporting CRCG County: ANDERSON

County of Residence:

Type of Staffing:

Case Number:

- 6) **Case Number:** Enter the Case Number. This is a unique number based on a numbering sequence that has been created by the local CRCG. Please note that the Initial Staffing Case Number cannot be more than 12 characters in length, including spaces and dashes.
- Do not use individual names in the Case Number. A good method for determining case numbers is to use the year as the first part of the case number and add a number at the end to identify the individual plan. For example, 2007-1 would identify the first service plan completed at the first meeting in calendar year 2007. (Some CRCGs have created a cross-reference table for local use to easily identify the individual and assigned case number.)
 - If you enter an Initial Staffing Case Number that already exists for that Monthly Staffing, an error message will appear prompting you to click on the Back button twice to re-enter a different Initial Staffing Case Number.
 - Note: The case number will be required if there is a need to refer back to previously submitted data submissions, and/or when follow-up documentation is to be entered.
- 7) **Referral Source:** Select the agency, organization or other choice that indicates the source of the referral. There is generally **one** entity that makes the referral; however, the form allows multiple selections when there is more than one referral source. Agencies are the same as those listed under the CRCG Meeting Information form. This section is looking **only** for the referring entity; not overall attendance at the staffing.
- 8) **Consumer Attendance:** Select “Yes” or “No” to indicate if the referred consumer (adult or child) attended the meeting. Select “Yes”, “No”, or “N/A” to indicate if the family member, caregiver, or guardian attended the meeting. Note: N/A should **only** be selected if a referred **adult** does not have a family member or caregiver or chooses not to have them attend the meeting. When a minor or person with a guardian is referred, the family or guardian should be invited to attend the CRCG meeting. If the referred consumer or the family member/caregiver/guardian was not present, select all applicable reasons for not attending. (If needed, enter a brief narrative statement in “Other” category.)

Consumer Attendance		
1. Did the referred consumer (adult or child) attend the staffing? <input type="radio"/> Yes <input type="radio"/> No		
2. Did the family, caregiver, or guardian attend the staffing? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A		
If 'No' was selected, indicate the reason(s) that 1. (consumer) and/or 2 (family, caregiver, or guardian) did not attend (select all that apply):		
Reason(s) for not attending	Consumer	Family, Caregiver, Guardian
Transportation Problems	<input type="checkbox"/>	<input type="checkbox"/>
Language/Communication Barriers	<input type="checkbox"/>	<input type="checkbox"/>
Meeting Location	<input type="checkbox"/>	<input type="checkbox"/>
Scheduling of Meeting	<input type="checkbox"/>	<input type="checkbox"/>
Declined - Chose not to Attend	<input type="checkbox"/>	<input type="checkbox"/>
Health or Other Physical Limitations	<input type="checkbox"/>	<input type="checkbox"/>
Unable to Contact	<input type="checkbox"/>	<input type="checkbox"/>
Safety (behavior presents concerns for safety of self or others)	<input type="checkbox"/>	<input type="checkbox"/>
Unknown	<input type="checkbox"/>	<input type="checkbox"/>
Other (describe)	<input type="text"/>	

- 9) **Service Needs:** This section includes 10 categories for Needs, each with multiple subcategories.
- Select all items that apply, based on the information provided by the referring entity, the consumer, and/or the parent /family member/caregiver/guardian.
 - Repeat the selection process for each of the 10 Service Needs categories that are applicable for the service plan being reported.
 - Note that each category offers the option “Other” category to provide brief narrative responses if necessary. **DO NOT SUBMIT CLIENT IDENTIFYING INFORMATION IN THE “OTHER” CATEGORY.**
- 10) **Agencies Contributing Resources or Services:** Select **all** agencies/organizations that have agreed to *contribute* resources toward completion of the service plan.
- 11) **Questions Specific to Children/Youth and/or Adults**
- If the referred individual is a **child or youth**, select the appropriate responses to the following questions:
 - Are Non-Educational funds being sought? (Select yes or no).
 - Is this service plan a result of the permanency planning notification requirement for children with developmental disabilities in institutional settings? (As per [Senate Bill 368, 77th Legislature, 2001](#). Select yes or no).
 - Is the child or youth at risk of out-of-home placement? (Select yes or no).
 - Is the CRCG recommending a placement? (Select yes or no).
 - If the CRCG is recommending a placement, select the placement that is being recommended. Use the “Other” category to enter a placement that is not listed, or if brief further explanation is required.
 - Is the child returning from an out-of-home placement? (Select yes or no).

Referred Children/Youth		
Are Non-Educational funds being sought?	<input type="radio"/> Yes	<input type="radio"/> No
Is this CRCG service plan a result of the permanency planning notification requirement for children with developmental disabilities in institutional settings?	<input type="radio"/> Yes	<input type="radio"/> No
Is the child or youth at risk of out of home placement?	<input type="radio"/> Yes	<input type="radio"/> No
Is the CRCG recommending a placement?	<input type="radio"/> Yes	<input type="radio"/> No
If yes, what is the recommended placement?		
<input type="radio"/> Waco Center for Youth	<input type="radio"/> North Texas State Hospital (Vernon Campus)	
<input type="radio"/> Nursing Facility	<input type="radio"/> ICF-MR including an MHMR State School	
Other: <input type="text"/>		
Is the child returning to the community from an out of home placement?	<input type="radio"/> Yes	<input type="radio"/> No

b) If the referred individual is an **adult**, select the appropriate responses to the following questions:

- Is the person at risk of out-of-home placement? (Select yes or no).
- If yes and an out-of-home placement is being considered, select the placement being considered. Use the “Other” category to enter a placement that is not listed or if brief further explanation is required.
- Is the person returning from an out of home placement? (Select yes or no).

Referred Adult	
Is the person at risk of out of home placement?	<input type="radio"/> Yes <input type="radio"/> No
If yes, what placement is being considered?	
<input type="radio"/> Assisted living facility	<input type="radio"/> Mental health treatment facility
<input type="radio"/> Nursing Facility	<input type="radio"/> ICF-MR including an MHMR State School
<input type="radio"/> Substance abuse treatment facility	
Other:	
<input type="text"/>	
Is the person returning to the community from an out of home placement?	<input type="radio"/> Yes <input type="radio"/> No

12) **Agreement with the Service Plan:** This question documents whether the parent, guardian, or adult consumer is in agreement with the service plan. Select the appropriate response: Yes, No, or Unknown. If nothing is clicked here, when you click the button, you will receive an error message stating “Please specify whether parent/guardian/adult consumer is in agreement with the service plan.”

13) **Review and Submit the Initial Staffing Form:** When you have completed all the items on the Initial Staffing Form, click on the button. Check the summary for accuracy and use the button of your browser to make any corrections. In the event that some important sections have been left blank, *red reminder* messages will appear with specific instructions regarding the information that may be missing so that you are able to make corrections before final submission. You will get the *red reminder* message if you do not identify any referring entities or participating entities that are contributing resources for a staffing. It is not an error to submit an initial staffing if you do not have a referring entity or participating entities for a staffing, but in most cases this information is missing due to a data entry error. Once you have reviewed the summary for accuracy, click on the button to submit your plan to the online system.

Monthly ID: 3082		
Monthly Meeting Date: 1/1/2007		
CRCG Type: Family		
County of Residence: ANDERSON		
Staffing Type: Full Staffing		
Staffing ID: 01012007-001		
Referring Agencies		
Workforce Agency		Other Type
Consumer Attendance		
1. Did the referred consumer (adult or child) attend the staffing? Yes		
2. Did the family, caregiver, or guardian attend the staffing? No		
Reason(s) for not attending	Consumer	Family, Caregiver, Guardian
Transportation Problems		<input type="checkbox"/> Yes
Language/Communication Barriers		
Meeting Location		
Scheduling of Meeting		<input type="checkbox"/> Yes

- 14) A page confirming the individual service plan data has been completely submitted will confirm the case number, monthly meeting ID, meeting date, and CRCG type. Step 2 is to enter the demographic and diagnostic information for the referred individual(s). Click the  button.

Thank you for submitting your Initial Staffing data for case **01012007-001**
 MonthlyID: **1/1/2007**
 Monthly Meeting Date: **3082**
 CRCG Type: **Family**

Step 2 - Enter Demographic and Diagnostic Information for the Referred Individual(s)



15) **Demographic and Diagnostic Information for the Referred Individual(s):**

- a) Type in the age and select the appropriate gender, ethnicity, and insurance status for the referred individual. If there is more than one referred individual, complete the information for both referred individuals on separate lines.

Staffing Case Number: **01012007-001**
 Monthly Meeting Date: **1/1/2007**
 Monthly ID: **3082**
 CRCG Type: **Family**

Demographic and Diagnostic information for Referred Individual(s)

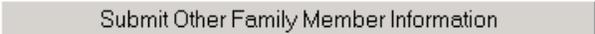
Recipient	Age	Gender	Ethnicity	Insurance Status
1	32	Male	White	None
2	16	Female	White	CHIP

- b) Select all known documented diagnoses for referred individuals. Select “Other” and enter known documented diagnoses that are not listed. **Note: Provide information only on diagnoses that are documented in the individual’s records.** Select “No Known Diagnosis” if the individual’s records do not include a formal diagnosis. Select “Diagnosis Information Not Available” if applicable.

Click the  button to show a summary of data entered. Click the  to finalize submission to the online system.

You have submitted data for the Referred Individuals for Staffing Case **01012007-001** for the Monthly staffings on **1/1/2007** (Monthly ID is **3082**).

Step 3 (If Applicable) - Enter demographic information for other family members for whom the service plan identifies a service or resource



[Enter another Initial Staffing for this Monthly Meeting](#)

[Return to Staffing forms home](#)

- 16) **Demographic Information for Other Family Members for whom the service plan identifies a service or resource, if applicable.** If there are other family members for whom services were identified (parenting skills training, etc.),

If you don't have the Monthly Meeting ID or want to look for a range of Monthly Meetings, select the choices below.

County:	- Select a County-		
Monthly Meeting Date	From	January	/1/2007
	To:	January	/1/2007

Go! Reset

that information should be captured here. Click the

Submit Other Family Member Information

- a) Enter the number of other family members for whom this service plan identifies a service or resource. Click the

Add Other Family Members

button.

Monthly Meeting Date: 1/1/2007
 Monthly ID: 3082
 CRCG Type: Family

Other Family Member Information

Enter the number of other family members for whom this service plan identifies a service or resource: 01012007-001

Add Other Family Members

- b) Enter the age and select the appropriate gender, ethnicity, and insurance status for each additional family member for whom the service plan identified a service or resource.

- 17) A confirmation of submission page will pop up. This page will allow you to select from submitting another initial staffing for the same monthly meeting, submitting a new CRCG meeting, submitting a follow-up, or go back to the staffing form home page.

The recipients information for Case Number 01012007-001 has been submitted to the database.

Select from the following choices:

Submit another initial staffing for Monthly Meeting date of 1/1/2007 (Monthly ID is 3082)

Go!

[Submit a new Monthly Meeting](#)

[Submit a follow-up](#)

- 18) **Additional Initial Service Plans for same meeting date:** To submit another initial service plan (staffing) for the same monthly meeting date, click on the **Go!** button.

19) **To Enter Initial Service Plan Information for a Previously Submitted Monthly Meeting:** Click [Go back to staffing form home](#), then click [Enter Initial Staffings](#).

- a) If the Monthly Meeting ID is known, enter the number in the box and click on the **Go!** button.

Enter an Initial 2007 Staffing

Find an initial staffing:

If you know the Monthly Meeting ID that to enter a new initial staffing form for that Monthly Meeting.

Monthly Meeting ID:

- b) To identify the Monthly Meeting ID, select the county and a date range and click on the **Go!** button.
- c) From the list of available Monthly Meetings, identify the appropriate meeting and click the **Show this record** link in the right hand column.

2007 Monthly Meeting(s) available for Initial Staffings

[Search for other Initial Staffings](#)

[Staffing Forms Home](#)

You found **2 records**.

You can sort by Monthly ID, Monthly Meeting Date or CRCG Type. Click on the Column name to sort Ascending or click on the Z-A icon to sort Descending.

Monthly Meeting Date Z↓ A↑	Monthly ID Z↓ A↑	CRCG Type Z↓ A↑	CRCG County	
1/5/2007	1	Children and Youth	ANDERSON	Show this record
1/1/2007	3082	Family	ANDERSON	Show this record

- d) Complete Steps 1 – 17 above.

FOLLOW-UP FORM – ONLINE SYSTEM

Frequently, the local CRCG requires more than one meeting to complete the activities in the staffing. When the local CRCG has received information regarding the follow-up activities that have occurred on behalf of a specific staffing, that data should be reported using the **Follow-Up Form**. In order to create a Follow-Up, you must find the Initial Staffing for that individual. This ensures that any follow-up data submitted is based on the previously submitted Initial Staffing.

- 1) Start at the 2007 Integrated Staffing Forms Home Page.
- 2) If you have not already entered monthly meeting information for the current meeting, do so first by clicking **Enter a Monthly Meeting**. Complete the CRCG Meeting Information process and return to the home page to enter follow-ups. **PLEASE NOTE:** The Monthly Meeting ID number that is generated will be used only for follow-ups to initial staffings completed at this meeting.
- 3) Click on the link **Enter Follow-ups** and identify the system where the initial staffing was submitted. Select the appropriate choice, and click on the **Go!** Button.

Enter Follow-Up

Select from the choices below:

Enter a follow-up for a 2007 Initial Staffing submitted to the **New Integrated Staffing System** (all populations served).

Enter a follow-up for a pre-2007 Initial Staffing submitted to the Old Integrated Staffing System (all populations served).

Follow-up to an Initial Service Plan entered in the Pre-2007 System

To enter a follow-up in the 2007 Integrated Data Collection System based on an initial staffing that was submitted prior to 2007:

- 4) The **Submit a Follow-up Form** link provides 2 ways to find an initial staffing:
 - If you know the monthly meeting ID number, enter the number and click on the **Go!** button.
 - If you don't know the monthly meeting ID number, select the county, select a beginning and ending date range, and click on the **Go!** button.
- 5) Identify the initial staffing you want and click **Show This Record** in the right column. The system will display the initial staffing header information.



Initial Staffing Search Result

Staffing form: **1**
County of Residence: **ANDERSON**
CRCG Type: **Children and Youth**
MonthlyID: **2546**

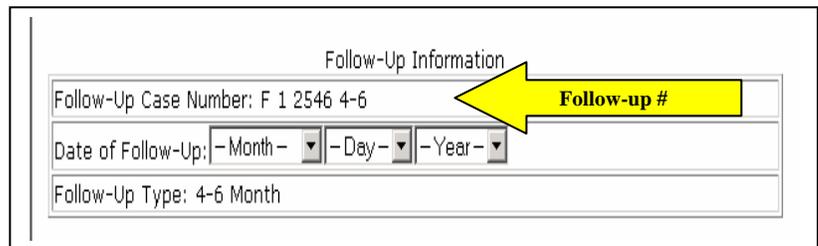
New Follow-up Form based on this staffing.
Select the type of Follow-up you would like to submit

1-3 Month 4-6 Month

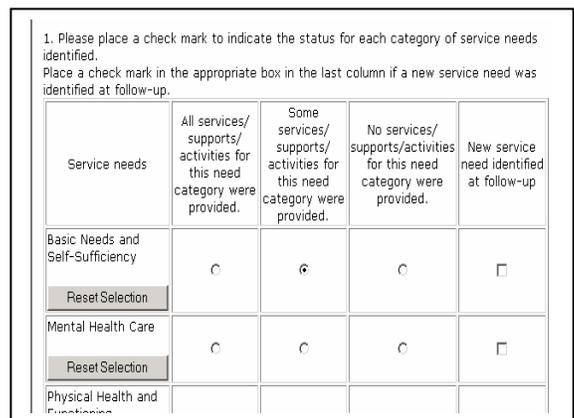
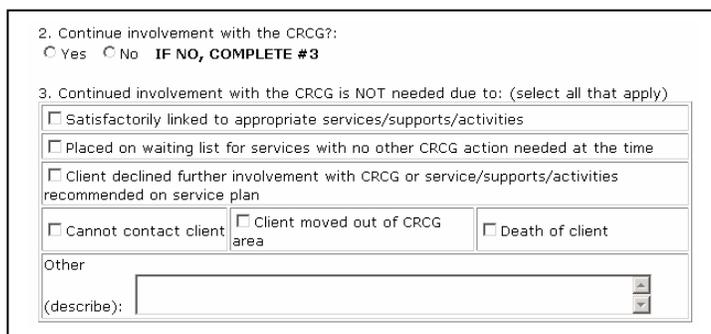
Other:

- 6) Identify the type of follow-up (1-3 month, 4-6 month, Other) and click on the  button. NOTE: For the “Other” category, please note a date or timeframe for a unique identifier (i.e. 7 month, 23 months, 1/1/08).

- 7) The form will display an expanded follow-up case number and follow-up period. Use the drop down menus to enter the date of follow-up.



- 8) Click the appropriate status for each service need category identified at the initial staffing (All, Some, or No services/supports/activities for this need category were provided.) If a need category was not identified at the initial staffing, leave the row blank. If something was selected accidentally, click the  button to clear that row.
- 9) Click the last column if new service needs were identified at the follow-up.

- 10) Click yes or no to indicate if there will be continued involvement with the CRCG.
- 11) If continued involvement with the CRCG is **not** needed, click all the appropriate reasons why continued involvement is not needed. Use the “Other” category to enter a brief statement if needed.

- 12) **IMPORTANT:** Select **all** barriers to accomplishing the services/supports/activities recommended on the service plan, regardless of whether continued involvement is necessary. Use “Other” to enter a *brief* statement if needed.
- 13) Use the “Comments” section to enter short success stories or other information needed to be shared with the State Office. Do **NOT** enter identifying information!
- 14) Click on the  button. A summary sheet will come up.
- 15) Print this page for your records and click on the  button.

Follow-up to CY 2007 System

To enter a follow-up for an initial staffing that was submitted to the CY 2007 Integrated Data Collection System:

- 1) The **Submit a Follow-up Form** link provides 2 ways to find an initial staffing:
 - If you know the monthly meeting ID number, enter the number and click on the **Go!** button.
 - If you don't know the monthly meeting ID number, select the county, select a beginning and ending date range, and click on the **Go!** button.
- 2) Identify the initial staffing you want and click **Show this record** in the right column.
- 3) Identify the type of follow-up (1-3 month, 4-6 month, Other) and click on the **Generate Follow-Up Form** button. NOTE: For "Other," please note a date or timeframe for a unique identifier (i.e., 7 month, 23 months, 1/1/08).
- 4) Complete follow-up form (see instructions 7 - 15 in the preceding section).

Section 2 - Paper Form Data Collection

Contact the Office of Program Coordination for Children and Youth at (512) 424-6963 for additional copies of the paper forms or download them from the CRCG website:

http://www.hhsc.state.tx.us/crcg/CRCGData/Enter_CRCG_Data.html.

CRCG MEETING INFORMATION – PAPER FORM

- 1) Complete this page **once** for each CRCG meeting.
- 2) Enter the name of your CRCG. If your CRCG is simply known by the names of the counties it serves, enter that information.
- 3) Enter the county where the meeting was **held**. NOTE: This is the county under which all staffings completed at this meeting will be recorded.
- 4) Select the type of CRCG or population served. The choices include: Children and Youth (CRCG for Children and Youth), Adults (CRCG for Adults), and Families (CRCG for Families).
- 5) Enter the month, day and year of the meeting.
- 6) Indicate meeting attendance by checking the box beside each agency or program that attended the meeting. (Note: The full agency names are supplied at the bottom of this form.)
- 7) Make a copy for your files and mail, e-mail or fax a copy to the State Office. Attach and initial service plans and follow-ups conducted at the meeting.

INITIAL SERVICE PLAN (STAFFING) – PAPER FORM

- 1) **County of Residence:** Enter the county of the permanent address of the referred individual(s).

Enter an **Initial Staffing Case number**. This is number unique based on a numbering sequence that has been created by the local CRCG. Please note that the Initial Staffing Case Number cannot be more than 12 characters in length, including spaces and dashes.

- a) Do not use individual names in the Case Number. A good method for determining case numbers is to use the year as the first part of the case number and add a number at the end to identify the individual plan. For example, 2007-1 would identify the first service plan completed at the first meeting in calendar year 2007. (Some CRCGs have created a cross-reference table for local use to easily identify the individual and assigned case number.)
 - b) If you enter an Initial Staffing Case Number that already exists for that Monthly Staffing, an error message will appear prompting you to click on the Back button twice to re-enter a different Initial Staffing Case Number.
 - c) Note: The case number will be required if there is a need to refer back to previously submitted data submissions, and/or when follow-up documentation is to be entered.
- 2) **Date of Staffing:** Enter the month, day, and year of the staffing.
- 3) **Staffing Type:** Select the type of staffing that is being documented. Choices include:
- a) Full Staffing: Service plan developed at a regular CRCG meeting.
 - b) Emergency Staffing: Individual is in crisis and needs immediate assistance – selected members may develop the plan. (This includes staffings completed via phone.) and
 - c) Resource/Referral Staffing: Discussion for the purpose of identifying one or more resources to which an individual or a member agency may apply for assistance. This also includes staffings completed via phone.
- 4) **Referral Source:** Select the agency, organization or other choice to indicate the source of the referral. There is generally one entity that makes the referral; however, it is okay to select more than one if the referral came from more than one agency or organization. Agencies are the same as those listed under the CRCG Meeting Information form. This section is looking **only** for the referring entity; not attendance at the staffing.
- 5) **Consumer Attendance:** Select “Yes” or “No” to indicate if the referred consumer (adult or child) attended the meeting. Select “Yes,” “No,” or “N/A” to indicate if the family member, caregiver, or guardian attended the meeting. Note: N/A should only be selected if a referred adult does not have a family member or caregiver or chooses not to have them attend the meeting. When a minor or person with a guardian is referred, the family or guardian should be invited to attend the CRCG meeting. If the referred consumer or the family member/caregiver/guardian was not present, select all applicable reasons for not attending. (If needed, enter a brief narrative statement in the “Other” category.)

- 6) **Service Needs:** This section includes 10 categories for Needs, each with multiple subcategories.
- a) Select all items that apply, based on the information provided by the referring entity, consumer, and/or the parent /family member/caregiver/guardian.
 - b) Repeat the selection process for each of the 10 Service Needs categories that are applicable for the service plan being reported.
 - c) Note that each category offers the option ‘Other’ to provide BRIEF narrative responses if necessary. **DO NOT SUBMIT CLIENT IDENTIFYING INFORMATION IN THE “OTHER” CATEGORY.**
- 7) **Agencies Contributing Resources or Services:** Select all agencies/organizations that have agreed to contribute resources toward completion of the service plan.
- 8) **Questions Specific to Children/Youth and/or Adults**
- a) If the referred individual is a **child or youth**, select the appropriate responses to the following questions:
 - Are Non-Educational funds being sought? (Select yes or no).
 - Is this staffing a result of the permanency planning notification requirement for children with developmental disabilities in institutional settings? (As per [Senate Bill 368, 77th Legislature, 2001](#). Select yes or no).
 - Is the child or youth at risk of out of home placement? (Select yes or no).
 - Is the CRCG recommending a placement? (Select yes or no).
 - If the CRCG is recommending a placement, select the placement that is being recommended. Use the “Other” category to enter a placement that is not listed or if BRIEF further explanation is required.
 - Is the child returning from an out of home placement? (Select yes or no).
 - b) If the referred individual is an **adult**, select the appropriate responses to the following questions:
 - Is the person at risk of out-of-home placement? (Select yes or no).
 - If yes and an out-of-home placement is being considered, select the placement being considered. Use the “Other” category to enter a placement that is not listed or if *brief* further explanation is required.
 - Is the person returning from an out-of-home placement? (Select yes or no).
- 10) **Agreement with the Service Plan:** This question documents whether the parent, guardian, or adult consumer is in agreement with the service plan. Select the appropriate response: Yes, No, or Unknown.

- 11) **Demographic and Diagnostic Information for the Referred Individual(s):**
 - a) Enter the age and select the appropriate gender, ethnicity, and insurance status for the referred individual. If there is more than one referred individual, complete the information for both referred individuals.
 - b) Select all known documented diagnoses for referred individuals. Select the “Other” category and enter known documented diagnoses that are not listed. **Note: Provide information only on diagnoses that are documented in the individual’s records.** Select “No Known Diagnosis” if the individual’s records do not include a formal diagnosis. Select “Diagnosis Information Not Available” if applicable.
- 12) **Demographic Information for Other Family Members for whom the Service Plan identifies a service or resource.** If there are other family members for whom services were identified (parenting skills training, etc.), that information should be captured here.
- 13) Make a copy for your files and mail, e-mail, or fax a copy to the Office of Program Coordination for Children and Youth.

FOLLOW-UP – PAPER FORM

Frequently, the local CRCG requires more than one meeting to complete the activities in the staffing. When the local CRCG has received information regarding the follow-up activities that have occurred on behalf of a specific service plan, that data should be reported using the **Follow-Up Form**.

- 1) Enter the case number and date (month, day, and year) for the **initial staffing**. (Contact the State Office at (512) 424-6963 if you need help identifying a case number or date of initial staffing.)
- 2) Enter the date of the follow-up.
- 3) Select the appropriate follow-up period (1-3 month, 4-6 month, Other). For “Other,” please note a date or timeframe for a unique identifier (i.e., 7 month, 23 months, 1/1/08).
- 4) Enter the CRCG Reporting County (county where initial staffing CRCG meeting was held).
- 5) Select the appropriate status for each service need category **identified** for the initial staffing (All, Some, or No services/ supports/activities for this need category were provided.) Do not select anything for those service categories **not** identified.
- 6) Check the box in the last column if there were new service needs identified at follow-up.
- 7) Click yes or no to indicate if there will be continued involvement with the CRCG.
- 8) If continued involvement with the CRCG is **not** needed, select all the appropriate reasons why continued involvement is not needed. Use “Other” to enter a brief statement if needed.
- 9) **IMPORTANT:** Select all barriers to accomplishing the services/supports/activities recommended on the service plan, regardless of whether continued involvement is necessary. Use “Other” to enter a brief statement if needed. and complete the follow-up page.
- 10) Use the “Comments” section to enter short success stories or other information needed to be shared with the State Office. Do **NOT** enter identifying information!
- 11) Make a copy for your records and mail, e-mail, or fax to the Office of Program Coordination for Children and Youth.

Data Glossary

Advocacy Organization – An organization whose primary mission is supporting a specific cause, idea, or policy.

Agency Participation – Agencies that have agreed to contribute resources toward completion of the service plan “staffing.”

Agreement With the Service Plan – A determination of whether the parent, guardian, or adult consumer is in agreement with the service plan.

Case Number – A unique number based on a numbering sequence that has been created by the local CRCG. The number will be required in order to refer back to previous data submissions, and/or when follow-up documentation is to be entered.

Challenging Behavior – Behavior that causes disruption within a social setting or presents a potential threat to the safety of that individual or others in the area.

Community Action Agency – A non-profit organization whose mission involves activities to alleviate poverty. Community Action Agencies generally contract with a state agency to receive Community Service Block Grant funds for that purpose.

Community Living Skills – Skills that an individual may use while engaging in the activities of day-to-day living.

Client-Identifying Information – Any information regarding the person or family being served by the local CRCG. Information that should not be submitted includes: the person’s name, address, phone number, social security number, and any other information that would enable an outside observer to identify the specific person being observed.

Consumer Attendance – Indicates whether or not the consumer and/or family member or caregiver attended the Initial Staffing service plan meeting.

Consumer/Caregiver Standing Team Member – A regular CRCG member, who serves on either a CRCG for Adults (CRCA) or a CRCG for Families (CRCAF) and supports communication between the consumer or the caregiver and the CRCA/F. This member is a person who has personal life experience as either a consumer or a caregiver of a person with disabilities.

County of Residence – The county that pertains to the permanent address for the referred individual.

Emergency Staffing – A service plan developed when an individual is in crisis and needs immediate assistance; selected members may develop the plan via conference call.

Faith-Based – Pertains to private organizations that either provide services of a religious nature or are connected to a place of worship.

Full Staffing – A service plan developed at a regular CRCG meeting.

Housing Agency – May be a recognized housing authority. May also be a private organization whose purpose includes assisting individuals and families in obtaining low-cost housing.

Individual Service Plan – A unique plan developed through the CRCG process, to identify service needs developed in collaboration with the consumer, family member, and/or caregiver of the individual whose needs can only be met through inter-agency coordination cooperation.

Monthly Meeting ID – A unique computer-generated number assigned to each CRCG Meeting submitted to the online collection system.

Non-Educational Funds – Funds requested through the Education Service Center for eligible handicapped students who would remain or would have to be placed in residential facilities primarily for educational reasons without the provision of non-educational community-based support services.

Parent/Family Standing Team Member – A regular CRCG member, who serves on either a CRCG for Children and Youth or a CRCG for Families (CRCGF) and supports communication between the parent or family members and the CRCG/F. This member is a person who has previous personal life experience as either a parent or family member of a person with disabilities.

Parenting Skills Training – Curricula designed to enhance trainees' parenting skills. This training may include safety, nutrition, communication skills and information regarding child development and developmentally appropriate responses that support the child's health, welfare and educational growth.

Permanency Planning – An individualized planning process undertaken on behalf of children with developmental disabilities with the expected outcome that every child grows up in a family, benefiting from an enduring and nurturing relationship with an adult.

Referral Source – The agency, organization, family, or other choice that indicates the source of the referral. There is generally one entity that makes the referral; however, multiple entities can be specified when there is more than one referral source.

Resource/Referral Staffing – A discussion for the purpose of identifying one or more resources to which an individual or a member agency may apply for assistance.

Staffing – The type of initial service plan that is being documented. Choices include: Full Staffing, Emergency Staffing, and Resource/Referral Staffing.

Workforce Agency – An agency that contracts with the Texas Workforce Commission to provide job training, job-location and other work-related services. This entity may also provide limited support services such as transportation and childcare for the purpose of obtaining or maintaining employment.

CRCG Meeting Information

Complete this page only **once** for the entire CRCG meeting. This information may cover more than one staffing.

Name of CRCG:		County where CRCG meeting was held	
CRCG Type	<input type="checkbox"/> Children and Youth	<input type="checkbox"/> Adults	<input type="checkbox"/> Families
Date of Meeting (MM/DD/YYYY)			

Attendance: identify each agency, contractor, group or individual attending the CRCG meeting:

DFPS <input type="checkbox"/> CPS <input type="checkbox"/> APS <input type="checkbox"/> PEI	DARS <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Blind & Visually Impaired <input type="checkbox"/> Deaf & Hard of Hearing <input type="checkbox"/> ECI	DSHS <input type="checkbox"/> MH Center <input type="checkbox"/> Substance Abuse Sub-Contractor or Council <input type="checkbox"/> CSHCN	DADS <input type="checkbox"/> MRA/MR Center <input type="checkbox"/> Nursing Home <input type="checkbox"/> AAA <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> ICF/MR <input type="checkbox"/> Other DADS
TDHCA <input type="checkbox"/> Community Action agency <input type="checkbox"/> Housing agency	EDUCATION <input type="checkbox"/> ESC <input type="checkbox"/> ISD	WORKFORCE <input type="checkbox"/> Workforce agency	JUVENILE JUSTICE <input type="checkbox"/> TYC <input type="checkbox"/> JPD <input type="checkbox"/> TCOOMMI (youth)
CRIMINAL JUSTICE/ TDCJ <input type="checkbox"/> Adult Probation <input type="checkbox"/> Adult Parole <input type="checkbox"/> TCOOMMI (adult)	PRIVATE ORGANIZATIONS <input type="checkbox"/> Faith-Based <input type="checkbox"/> Non-Profit (Businesses, Individuals, etc.) <input type="checkbox"/> For-Profit (Businesses, Individuals, etc.) <input type="checkbox"/> Foundations		
<input type="checkbox"/> Advocacy organization	<input type="checkbox"/> Standing Team Member (Parent, Family, Consumer, Caregiver)	<input type="checkbox"/> Texas I&R 2-1-1	Other: _____ _____

DFPS – Texas Department of Family and Protective Services, **CPS** – Child Protective Services, **APS** – Adult Protective Services, **PEI** – Prevention and Early Intervention: Services to At-Risk Youth (STAR), Community Youth Development Grants, etc.

DARS – Texas Department of Assistive and Rehabilitative Services, **ECI** – Early Childhood Intervention

DSHS – Texas Department of State Health Services, **MH Center** – Community Mental Health and Mental Retardation Center – Mental Health Services, **CSHCN** – Children with Special Health Care Needs

DADS – Texas Department of Aging and Disability Services, **MRA** – Mental Retardation Authority, **MR Center** – Community Mental Health and Mental Retardation Center – Mental Retardation Services, **AAA** – Area Agency on Aging, **ICF/MR** – Intermediate Care Facility for Mental Retardation services

TDHCA – Texas Department of Housing and Community Affairs

EDUCATION - ESC – Education Service Center, **ISD** – Independent School District

JUVENILE JUSTICE - TYC – Texas Youth Commission, **JPD** – Juvenile Probation

TCOOMMI – Texas Correctional Office on Offenders with Medical or Mental Impairments for youth and adult

TDCJ – Texas Department of Criminal Justice

Initial Service Plan (Staffing) Form

County of Residence:		Case Number (assigned by local CRCG):		Date of staffing:	
Type of Staffing (choose one) <input type="checkbox"/> Full Staffing <input type="checkbox"/> Emergency Staffing <input type="checkbox"/> Resource/ Referral Staffing					
Referral Source(s)					
DFPS <input type="checkbox"/> CPS <input type="checkbox"/> APS <input type="checkbox"/> PEI		DARS <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Blind & Visually Impaired <input type="checkbox"/> Deaf & Hard of Hearing <input type="checkbox"/> ECI		DSHS <input type="checkbox"/> MH Center <input type="checkbox"/> Substance Abuse Sub-Contractor or Council <input type="checkbox"/> CSHCN	
DADS <input type="checkbox"/> MRA/MR Center <input type="checkbox"/> Nursing Home <input type="checkbox"/> AAA <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> ICF/MR <input type="checkbox"/> Other DADS		TDHCA <input type="checkbox"/> Community Action agency <input type="checkbox"/> Housing agency		EDUCATION <input type="checkbox"/> ESC <input type="checkbox"/> ISD	
WORKFORCE <input type="checkbox"/> Workforce agency		JUVENILE JUSTICE <input type="checkbox"/> TYC <input type="checkbox"/> JPD <input type="checkbox"/> TCOOMMI (youth)		CRIMINAL JUSTICE/ TDCJ <input type="checkbox"/> Adult Probation <input type="checkbox"/> Adult Parole <input type="checkbox"/> TCOOMMI (adult)	
PRIVATE ORGANIZATIONS <input type="checkbox"/> Faith-Based <input type="checkbox"/> Non-Profit (Businesses, Individuals, etc.) <input type="checkbox"/> For-Profit (Businesses, Individuals, etc.) <input type="checkbox"/> Foundations					
<input type="checkbox"/> Advocacy organization		<input type="checkbox"/> Standing Team Member (Parent, Family, Consumer, Caregiver) <input type="checkbox"/> Self <input type="checkbox"/> Family		<input type="checkbox"/> Texas I & R 2-1-1 Other: _____ _____ _____	
Consumer Attendance					
1. Did the referred consumer (adult or child) attend the staffing? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Did the family, caregiver, or guardian attend the staffing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A If 'No' was selected, indicate the reason(s) that 1. (consumer) and/or 2 (family, caregiver, or guardian) did not attend (select all that apply):					
Reason(s) for not attending		Consumer	Family, Caregiver, Guardian		
Transportation Problems		<input type="checkbox"/>	<input type="checkbox"/>		
Language/Communication Barriers		<input type="checkbox"/>	<input type="checkbox"/>		
Meeting Location		<input type="checkbox"/>	<input type="checkbox"/>		
Scheduling of Meeting		<input type="checkbox"/>	<input type="checkbox"/>		
Declined - Chose not to Attend		<input type="checkbox"/>	<input type="checkbox"/>		
Health or Other Physical Limitations		<input type="checkbox"/>	<input type="checkbox"/>		
Unable to Contact		<input type="checkbox"/>	<input type="checkbox"/>		
Safety (behavior presents concerns for safety of self or others)		<input type="checkbox"/>	<input type="checkbox"/>		
Unknown		<input type="checkbox"/>	<input type="checkbox"/>		
Other (Describe)		<input type="checkbox"/>	<input type="checkbox"/>		

Needs

Basic Needs and Self-Sufficiency (select all that apply):			
<input type="checkbox"/> Food	<input type="checkbox"/> Housing	<input type="checkbox"/> Short-term shelter	<input type="checkbox"/> Home repair/ modification
<input type="checkbox"/> Furniture	<input type="checkbox"/> Clothing	<input type="checkbox"/> Utilities	<input type="checkbox"/> Phone
<input type="checkbox"/> Transportation	<input type="checkbox"/> Personal safety	<input type="checkbox"/> Money management	<input type="checkbox"/> Financial Assistance to Meet Basic Needs
<input type="checkbox"/> Other: _____			
Mental Health Care (select all that apply):			
Outpatient Services			<input type="checkbox"/> Inpatient Treatment
<input type="checkbox"/> Assessment/ Evaluation	<input type="checkbox"/> Counseling	<input type="checkbox"/> Day Treatment	<input type="checkbox"/> Medication
<input type="checkbox"/> Other: _____			
Physical Health and Functioning (select all that apply):			
<input type="checkbox"/> Doctor/ Dentist Visit	<input type="checkbox"/> Special Equipment/supplies	<input type="checkbox"/> Medication	In-home care <input type="checkbox"/> Personal Care <input type="checkbox"/> Nursing
<input type="checkbox"/> Intensive Medical Care/Support (Hospitalization/Surgery/Hospice)	Other: _____		
Substance Abuse Services (select all that apply):			
<input type="checkbox"/> Prevention	<input type="checkbox"/> Intervention	<input type="checkbox"/> Treatment	<input type="checkbox"/> Other: _____
Family Support (select all that apply):			
<input type="checkbox"/> Respite	<input type="checkbox"/> Child Care	<input type="checkbox"/> Adult Day Care	<input type="checkbox"/> Other: _____
Legal Assistance (select all that apply):			
<input type="checkbox"/> Conservator	<input type="checkbox"/> Guardianship	<input type="checkbox"/> Criminal	<input type="checkbox"/> Benefits Counseling
<input type="checkbox"/> Other civil: _____	Other: _____		
Education (select all that apply):			
<input type="checkbox"/> Special equipment	<input type="checkbox"/> Truancy prevention	<input type="checkbox"/> Translator/Interpreter	<input type="checkbox"/> English as a second language
<input type="checkbox"/> Adult education	<input type="checkbox"/> Referral for special education services	<input type="checkbox"/> Other: _____	
Employment (select all that apply):			
<input type="checkbox"/> Employment assistance	<input type="checkbox"/> Vocational training	<input type="checkbox"/> Other: _____	
Social Interaction (select all that apply):			
<input type="checkbox"/> Mentor	<input type="checkbox"/> Opportunity to socialize	<input type="checkbox"/> Other: _____	
Skill Development (select all that apply):			
<input type="checkbox"/> Activities of daily living	<input type="checkbox"/> Community living skills	<input type="checkbox"/> Social skills	<input type="checkbox"/> Parenting skills training
<input type="checkbox"/> Problem-solving skills	<input type="checkbox"/> Budget management	<input type="checkbox"/> Challenging behavior	<input type="checkbox"/> Anger management
<input type="checkbox"/> Impulse control	<input type="checkbox"/> Other: _____		

Who is contributing resources or services to this service plan?			
DFPS <input type="checkbox"/> CPS <input type="checkbox"/> APS <input type="checkbox"/> PEI	DARS <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Blind & Visually Impaired <input type="checkbox"/> Deaf & Hard of Hearing <input type="checkbox"/> ECI	DSHS <input type="checkbox"/> MH Center <input type="checkbox"/> Substance Abuse Sub-Contractor or Council <input type="checkbox"/> CSHCN	DADS <input type="checkbox"/> MRA/MR Center <input type="checkbox"/> Nursing Home <input type="checkbox"/> AAA <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> ICF/MR <input type="checkbox"/> Other DADS
TDHCA <input type="checkbox"/> Community Action agency <input type="checkbox"/> Housing agency	EDUCATION <input type="checkbox"/> ESC <input type="checkbox"/> ISD	WORKFORCE <input type="checkbox"/> Workforce agency	JUVENILE JUSTICE <input type="checkbox"/> TYC <input type="checkbox"/> JPD <input type="checkbox"/> TCOOMMI (youth)
CRIMINAL JUSTICE/ TDCJ <input type="checkbox"/> Adult Probation <input type="checkbox"/> Adult Parole <input type="checkbox"/> TCOOMMI (adult)	PRIVATE ORGANIZATIONS <input type="checkbox"/> Faith-Based <input type="checkbox"/> Non-Profit (Businesses, Individuals, etc.) <input type="checkbox"/> For-Profit (Businesses, Individuals, etc.) <input type="checkbox"/> Foundations		
<input type="checkbox"/> Advocacy organization	<input type="checkbox"/> Standing Team Member (Parent, Family, Consumer, Caregiver) <input type="checkbox"/> Self <input type="checkbox"/> Family	<input type="checkbox"/> Texas I & R 2-1-1	Other: _____ _____ _____
Referred Children/Youth			
Are Non-Educational funds being sought? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this CRCG service plan a result of the permanency planning notification requirement for children with developmental disabilities in institutional settings? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is the child or youth at risk of out of home placement? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is the CRCG recommending a placement? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what is the recommended placement?		
	<input type="checkbox"/> Waco Center for Youth	<input type="checkbox"/> North Texas State Hospital (Vernon Campus)	<input type="checkbox"/> Nursing Facility
			<input type="checkbox"/> ICF-MR including an MHMR State School
<input type="checkbox"/> Other: _____			
Is the child returning to the community from an out of home placement? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Referred Adult			
Is the person at risk of out of home placement? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what placement is being considered?	<input type="checkbox"/> Assisted living facility <input type="checkbox"/> Mental health treatment facility <input type="checkbox"/> ICF-MR including an MHMR State School	<input type="checkbox"/> Nursing facility <input type="checkbox"/> Substance abuse treatment facility <input type="checkbox"/> Other	Is the person returning to the community from an out of home placement? <input type="checkbox"/> Yes <input type="checkbox"/> No
Agreement with Service Plan			
Is the parent/guardian/adult consumer in agreement with the service plan? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			

Demographic and Diagnostic Information for the Referred Individual(s)					
Recipient	Age	Gender		Ethnicity	Insurance Status
1		<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Other	<input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP <input type="checkbox"/> Private <input type="checkbox"/> Medicare <input type="checkbox"/> None <input type="checkbox"/> Unknown
2		<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Other	<input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP <input type="checkbox"/> Private <input type="checkbox"/> Medicare <input type="checkbox"/> None <input type="checkbox"/> Unknown
Information on known documented diagnoses for referred individual(s)					
<input type="checkbox"/> No known diagnosis			<input type="checkbox"/> Diagnosis information not available		
<u>Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence</u>					
<input type="checkbox"/> Mental Retardation		<input type="checkbox"/> Attention-Deficit/Hyperactivity Disorder			
<input type="checkbox"/> Pervasive Developmental Disorder (includes Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder)		<input type="checkbox"/> Conduct Disorder (the Antisocial Personality Disorder of Childhood)			
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Oppositional Defiant Disorder (not only for children)			
<u>Substance-Related Disorders</u>					
<input type="checkbox"/> Alcohol Dependence or Alcohol Abuse		<input type="checkbox"/> Inhalant Dependence or Inhalant Abuse			
<input type="checkbox"/> Cannabis Dependence or Cannabis Abuse		<input type="checkbox"/> Opioid Dependence or Opioid Abuse			
<input type="checkbox"/> Cocaine Dependence or Cocaine		<input type="checkbox"/> Phencyclidine Dependence or Phencyclidine Abuse (PCP)			
<input type="checkbox"/> Hallucinogen Dependence or Hallucinogen Abuse		<input type="checkbox"/> Other: _____			
<u>Psychotic Disorders</u>					
<input type="checkbox"/> Schizoaffective Disorder		<input type="checkbox"/> Schizophrenia		<input type="checkbox"/> Other: _____	
<u>Mood Disorders</u>					
<input type="checkbox"/> Bipolar I Disorder (mania with/without major depression)		<input type="checkbox"/> Major Depressive Disorder			
<input type="checkbox"/> Bipolar II Disorder (hypomania with major depression)		<input type="checkbox"/> Other: _____			
<u>Other Conditions</u>					
<input type="checkbox"/> Deaf or Hard of Hearing <input type="checkbox"/> Blind or Visual Impairment <input type="checkbox"/> Severe Mobility Impairment <input type="checkbox"/> Traumatic Brain Injury					
<input type="checkbox"/> Other Diagnoses or Conditions not listed above: _____					
Demographic Information for other Family Members for whom the Service Plan identifies a service					
Recipient	Age	Gender		Ethnicity	Insurance Status
1		<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Other	<input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP <input type="checkbox"/> Private <input type="checkbox"/> Medicare <input type="checkbox"/> None <input type="checkbox"/> Unknown
2		<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Other	<input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP <input type="checkbox"/> Private <input type="checkbox"/> Medicare <input type="checkbox"/> None <input type="checkbox"/> Unknown
3		<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Other	<input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP <input type="checkbox"/> Private <input type="checkbox"/> Medicare <input type="checkbox"/> None <input type="checkbox"/> Unknown

Follow Up Form

Case Number: _____ Date of Initial Staffing: _____ Date of Follow-up: _____

 1-3 Month 4-6 Month Other (please specify) _____

CRCG Reporting County: _____

1. Please place a check mark to indicate the status for each category of service needs identified. Place a check mark in the appropriate box in the last column if a new service need was identified at follow-up.

Service needs	All services/ supports/ activities for this need category were provided.	Some services/ supports/ activities for this need category were provided.	No services/ supports/activities for this need category were provided.	New service need identified at follow-up
Basic Needs and Self-Sufficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Health and Functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal Assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Interaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skill Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Continue involvement with the CRCG?: Yes (Complete #4) No (**If No, also complete # 3**)**3. Continued involvement with the CRCG is NOT needed due to: (select all that apply)**

<input type="checkbox"/> Satisfactorily linked to appropriate services/supports/activities	<input type="checkbox"/> Cannot contact client
<input type="checkbox"/> Placed on waiting list for services with no other CRCG action needed at the time	<input type="checkbox"/> Client moved out of CRCG area
<input type="checkbox"/> Client declined further involvement with CRCG or service/supports/activities recommended on service plan	<input type="checkbox"/> Death of client
<input type="checkbox"/> Other _____	

4. Barriers. Please indicate any barriers to accomplishing the services/supports/activities recommended on the service plan (choose all that apply):

<input type="checkbox"/> Physical access to services/supports/activities (includes transportation, communication, scheduling, language)
<input type="checkbox"/> Availability of services/supports/activities (includes lack of funding, waiting list, no service provider available, doesn't meet eligibility)
<input type="checkbox"/> Agency follow-up (includes difficulties such as insufficient staff, staff change, etc.)
<input type="checkbox"/> Family or individual's choice to not access or follow through with some aspect of service plan recommendations.
<input type="checkbox"/> Other _____

5. General comments on Individual Service Plan: _____

The Greener Pastures Foundation Grant Proposal
Submitted by The Collaboration Team of Blooming County

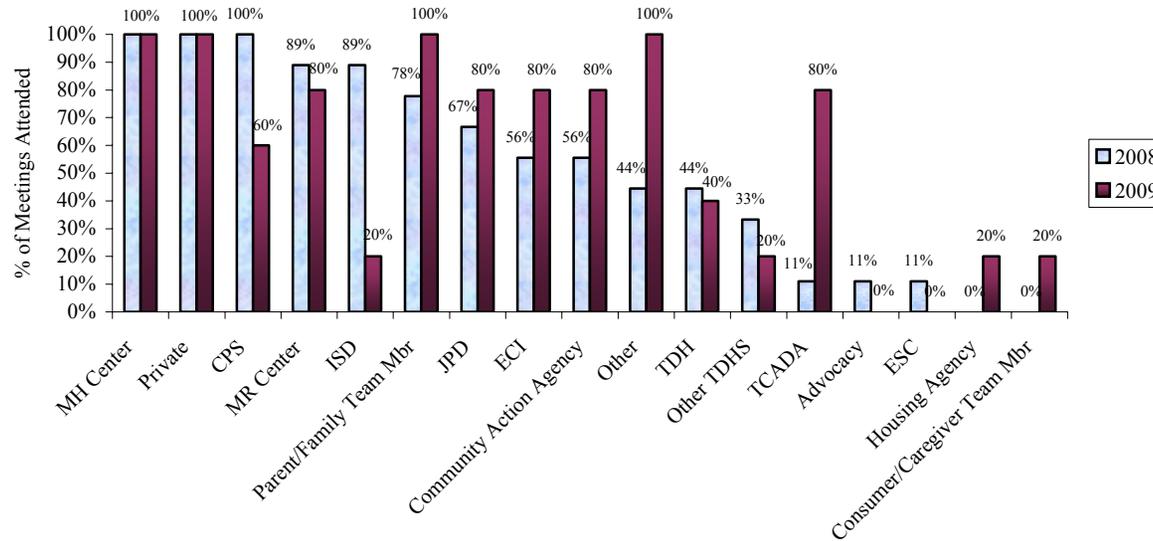
January 1, 2010



Abstract

The Blooming County Collaborative proposes to integrate its service delivery approach to children, youth, and adults in their community by As evidenced by the following data of our Community Resource Coordination Group:

**Blooming County CRCG Attendance at CRCG Meetings
9 CRCG Meetings Reported in Calendar Year 2008
5 CRCG Meetings Reported in Calendar Year 2009 as of 7/22/09**

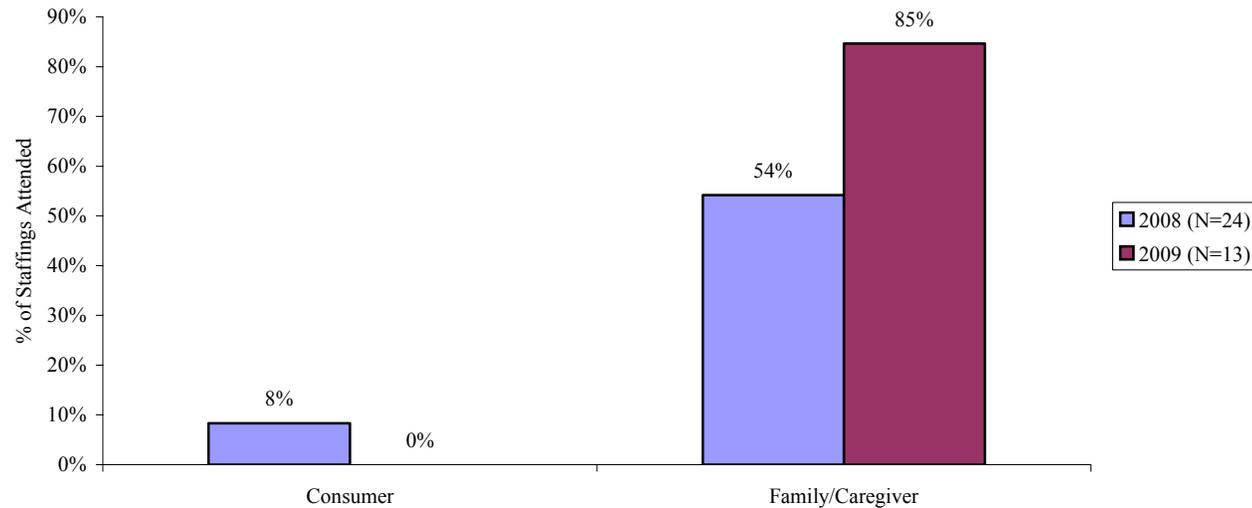


Blooming County reported 9 CRCG meetings in 2008 and 5 meetings to date in 2009. These meetings were attended by people from multiple agencies; sometimes multiple staff from a different division within one agency are needed. Staff from local MH centers and private organizations had 100% attendance at meetings for both years. Parent/Family Team Member attendance increased from 78% in 2005 to 100% to date in 2006. Other agencies/organizations noting improved attendance are JPD, ECI, community action agencies, other organizations, TCADA, local housing agencies, and consumer/caregiver team members. These percentages reflect the amount of time these members attended the CRCG meetings.

NOTE 1: Several CRCGs are no longer listing the legacy agencies when reporting attendance. These agencies often get listed as “Other,” thus accounting for the large number in this category.

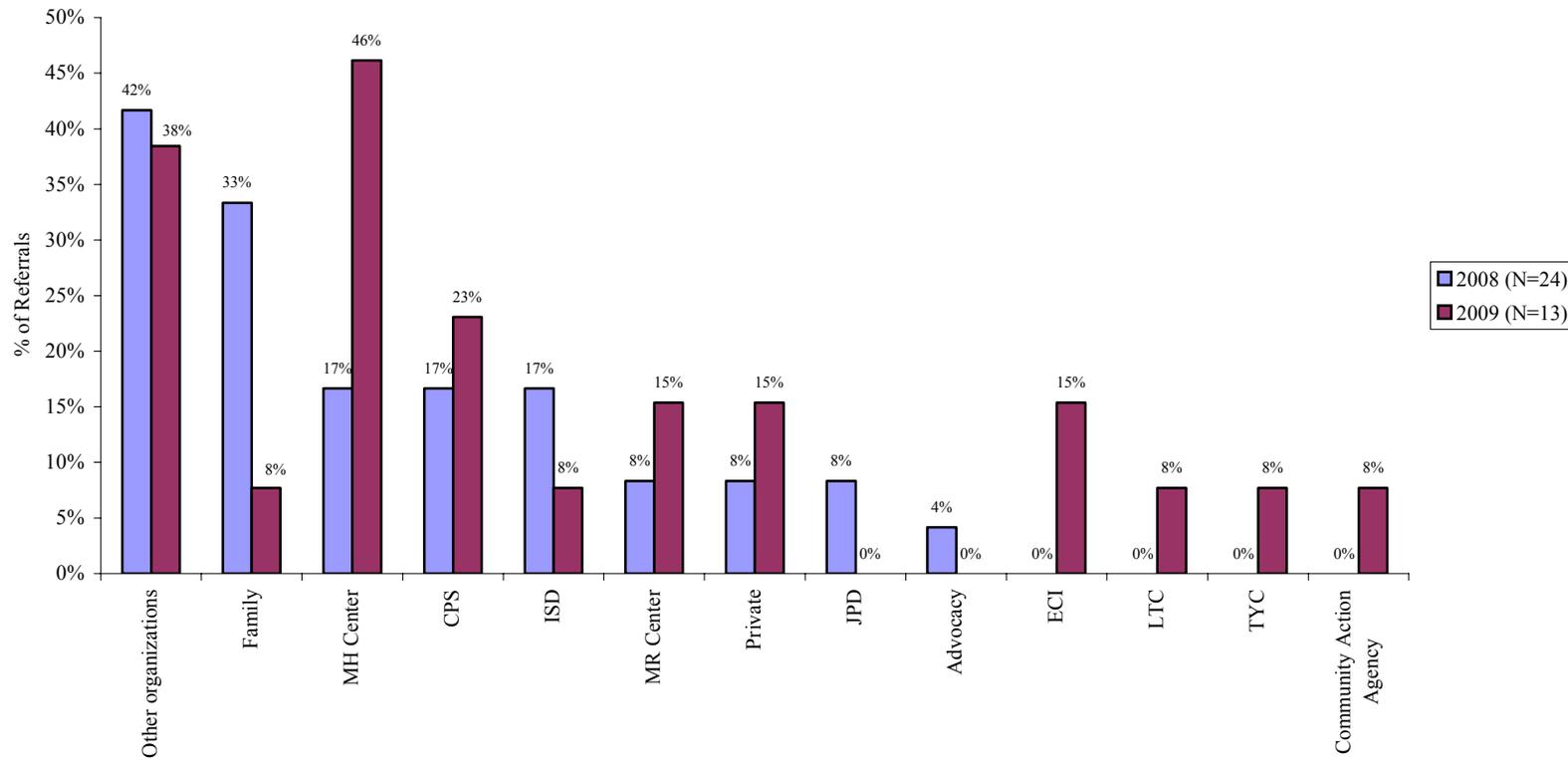
NOTE 2: Parent/Family Team Member and Consumer/Caregiver Team Member do not represent persons served, rather these represent standing team members.

Attendance at Blooming County CRCG Service Planning Meetings by Family, Consumers, or Caregivers



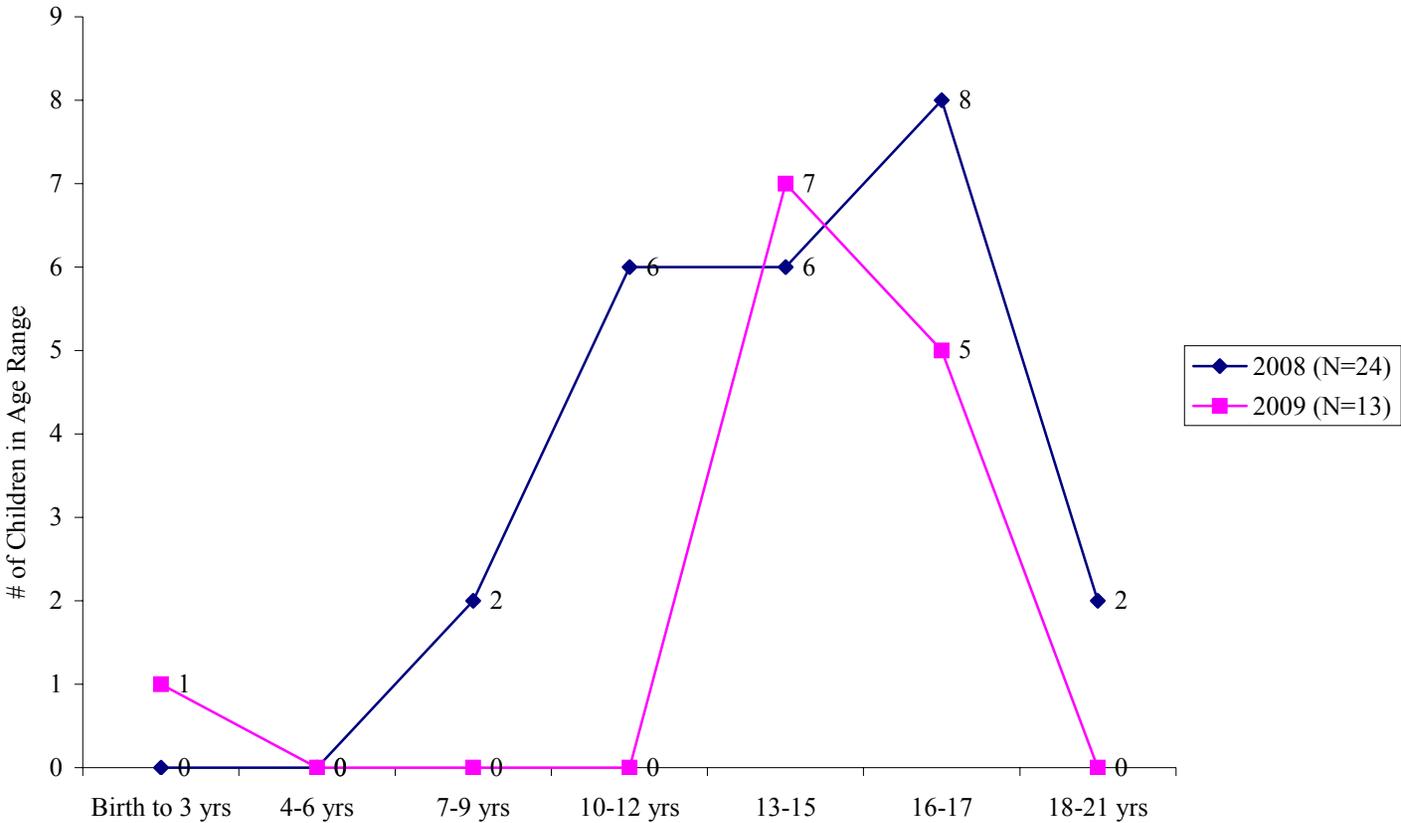
An important component of the CRCG is to plan **with** an individual or family, not “for” them. As such, it is important that the individual or family feel comfortable in meeting with the team as they plan for needed services and supports. The Blooming County CRCG for Children and Youth data indicates in 2008, 8% of the consumers attended staffings; none have been reported as attending to date for 2009. For 2008, Blooming County reported family and/or caregivers attending 54% of the meetings, increasing to 85% in 2009.

Blooming County CRCG Referral Sources



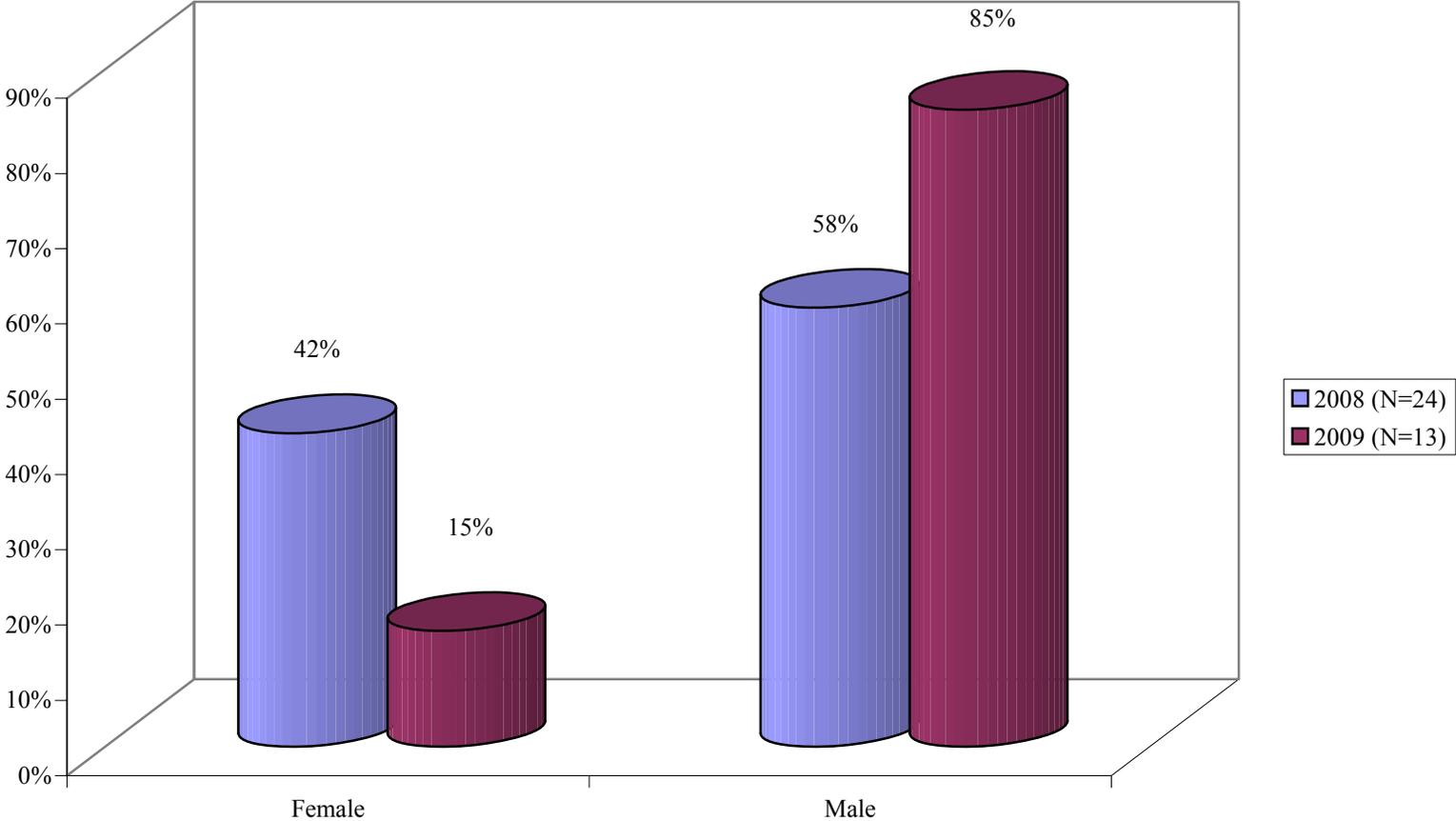
Of the 24 service plans submitted in calendar year 2008 and 13 submitted in 2009, each was initially referred by a member (or members) of the CRCG team. Other organizations made the most referrals in 2008 with 42%, while staff at local MH centers made the most referrals in 2009 with 46%. For some consumers, more than one agency was reported as the referring agency; therefore, the total percentage equals greater than 100%.

Demographics of Individuals Served by Blooming County CRCG



There were 24 initial service plans submitted for 2008 and 13 submitted for 2009. Ages of these individuals identified ranged from 2 years to 21 years of age, with the highest frequency occurring between the ages of 16-17 in 2008 and 13 and 15 to-date in 2009. This is in line with statewide trends.

Blooming County CRCG – Gender of Individuals Served



In 2008, 42% of the individuals served by Blooming County were females dropping to 15% to date in 2009. Fifty-eight percent (58%) of the individuals served in 2008 were males increasing to 85% to-date in 2009.

Needs Identified by CRCG Service Plans

Most CRCG Service Plans identified specific service needs for consumers, often identifying more than one need. Due to the complete transition to the integrated web-based system, data was more consistently gathered which, at least in part, led to higher numbers of needs being reported. Because most plans included more than one identified service need, the total percentage equals more than 100%.

Service Need Definitions and Ratings:

Skill Development (62%): Activities of daily living, community living skills, social skills, parenting skills, problem-solving skills, budget management, challenging behavior, anger management, impulse control and other similar skills

Mental Health (60%): Outpatient services such as assessment/evaluation, counseling, day treatment, and medication; inpatient treatment, and other related needs

Family Support (35%): Respite, child care, adult day care, parenting, budget/training

Social Interaction (30%): Mentoring, opportunities to socialize, and other requirements to be specified by family, care provider, case manager or CRCG

Basic Needs & Self-Sufficiency (26%): Food, housing, short-term shelter, furniture, clothing, cash or vouchers to meet basic needs, utilities, phone, personal safety, home repair or modification, transportation, money management, financial assistance to meet basic needs, and other related needs

Substance Abuse Services (19%): Prevention, intervention, treatment and any other related services

Education (16%): Special equipment, truancy prevention, translator/interpreter, English as a second language, adult education, and referral for special education services, and other services as required

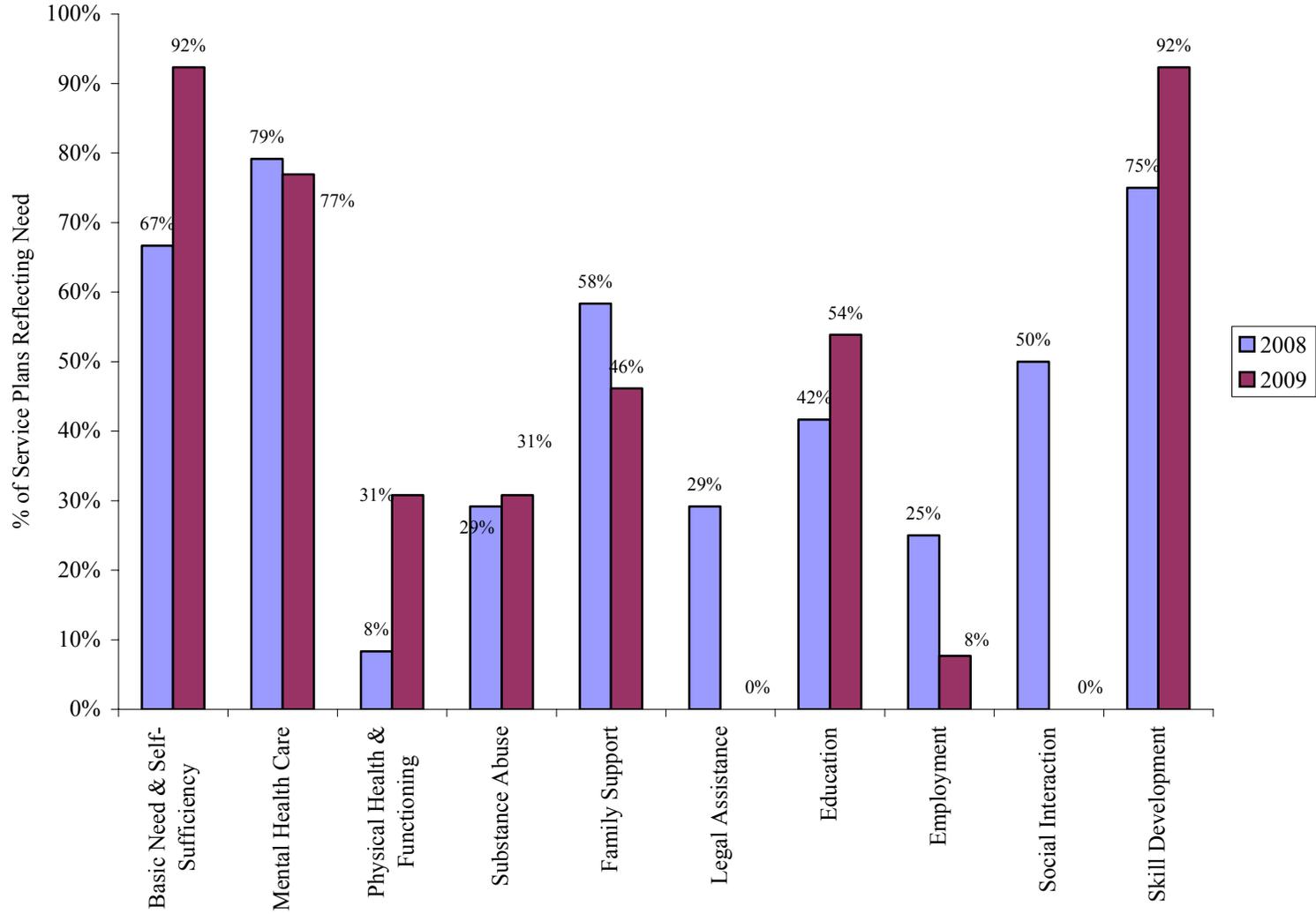
Legal Assistance (9%): Conservator, guardianship, criminal, benefits counseling, and other assistance as required

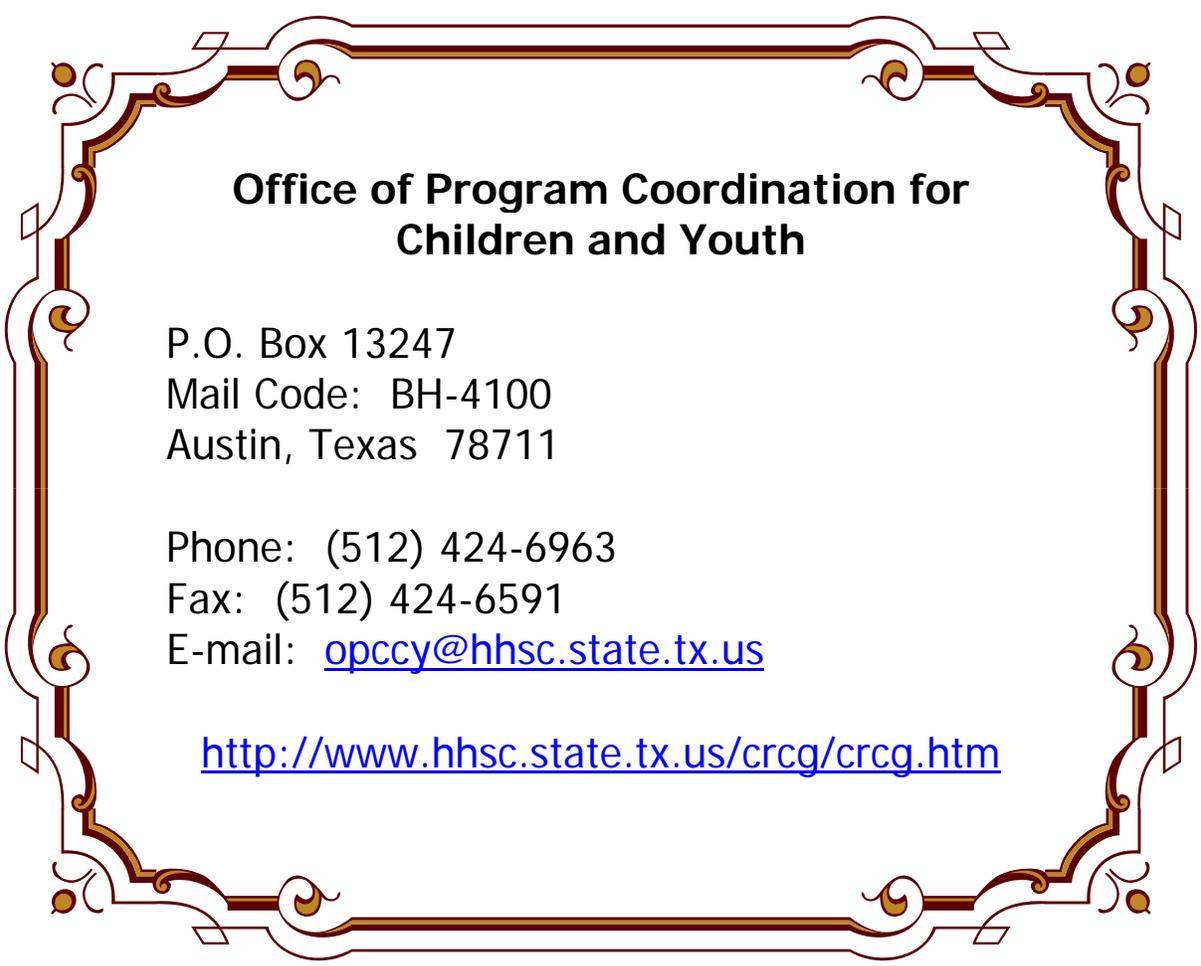
Physical Health & Functioning (9%): Doctor/dentist visit, special equipment/supplies, medication, in-home care that can be personal care, nursing, or both; intensive medical care/support (hospitalization/surgery/hospice)

Employment Assistance (6%): Employment placement and vocational training

Needs Identified by Blooming County CRCG Service Plans

There were 24 Initial Service Plans completed in 2008 and 13 to date in 2009.





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Children and Youth**

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