



**Early Childhood Mental Health Consultation**

**Family Child Care Referral Form**

**Referral Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Provider Information**

*Provider Name:* \_\_\_\_\_

*Address:* \_\_\_\_\_ *Phone:* \_\_\_\_\_

*Email:* \_\_\_\_\_ *EEC Program ID:* \_\_\_\_\_

*Preferred Language of Provider:* \_\_\_\_\_

*FCC System Name:* \_\_\_\_\_ *Contact Person Name:* \_\_\_\_\_

*Phone:* \_\_\_\_\_ *Email:* \_\_\_\_\_

**For Program Support:**

**Reason for Referral**

- Promoting Social Skills     Promoting Emotional Skills     Preventing/Managing Challenging Behavior
- Classroom routines     Classroom Organization     Improving Transition Periods     Building Classroom Community
- Strengthening relationships with children     Other (Please Specify): \_\_\_\_\_

What is provider seeking to accomplish through Mental Health Consultation Services? \_\_\_\_\_

**For Child/Family Support (consents required, please see attached):**

*Child's Name:* \_\_\_\_\_ *DOB:* \_\_\_\_\_ *Gender:* M  F

*Address:* \_\_\_\_\_

*Parent/Guardian Name:* \_\_\_\_\_ *Phone Number:* \_\_\_\_\_

*Child living with:*     Parent     Other Family Member     Foster Parent     Other \_\_\_\_\_

*Preferred Language of Parent/Guardian:* \_\_\_\_\_ *Child's Race/Ethnicity:* \_\_\_\_\_

*Type of Child Care Slot:*     Voucher     DCF Supportive     Private     Other

*Other services child is receiving/has received:*     Early Intervention     Individual/Family Therapy     FS&T/ICC/TM     IFSP     DCF

Special Education Evaluation     IEP     504

**Reason for Referral**

- Aggressive behavior - towards:     Children     Adults     Property     Self
- Attention difficulties     Extreme tantrums / lack of emotional control     Oppositional behavior
- Over activity/Impulsivity     Withdrawn/overly shy behavior     Developmental concerns
- Concerns with social skills/peer relations     Trauma     Sexualized behavior     Other (Please specify): \_\_\_\_\_

What is provider seeking to accomplish through Mental Health Consultation Services? \_\_\_\_\_



**Early Childhood Mental Health Consultation**

**Family Child Care Referral Form**

**Referral Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_**



### Consent for Services

**Child's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Name of Program:** \_\_\_\_\_

**Director:** \_\_\_\_\_ **Educator/Provider:** \_\_\_\_\_

**Program Address:** \_\_\_\_\_

**Program Telephone #:** \_\_\_\_\_ **Fax #:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Parent/Guardian(s):** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Preferred Telephone #(s):** \_\_\_\_\_

**E-mail (if agreeable to also being contacted this way):** \_\_\_\_\_

*Please check the boxes if consent is given; all boxes must be checked to be considered complete.*

- I give my permission for the above mentioned Child care Agency to exchange information about my child with MSPCC's Mental Health Consultation Team.
- I give my permission for MSPCC's Mental Health Consultation Team to provide some or all of the following services:
  1. Consultation with the child care program's staff regarding behavioral and/or social - emotional issues.
  2. Consultation with the parent or guardian.
  3. Observation of my child in the school/child care setting.
  4. Social-emotional, behavioral screening/assessment.
  5. Development of an individual behavior support plan.
  6. Recommendations for ongoing services.
- I understand that someone from the Mental Health Consultation Team will be contacting me and keeping me updated on all of the services that are recommended and/or provided.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date



**Early Childhood Mental Health Consultation  
Consent for Video Observation and Coaching Services**

**Child's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

By signing this form, I authorize MSPCC/Eliot Community Human Services to provide ongoing virtual observation and consultation services for my child as they collaborate with child-care staff regarding the development of social-emotional skills in young children. Services will include classroom observation and consultation regarding specific strategies to promote these skills.

Due to the current Department of Early Education and Care (EEC) Health and Safety Guidelines which prohibits outside visitors, observations will be provided using a virtual platform. Virtual observations will **NOT** be recorded. This virtual observation will only be accessible to assigned Early Childhood Mental Health Consultation staff and program director.

I understand that I have the right to withhold my consent to the use of virtual observation in the course of my child's consultation service at any time, without affecting my child's right to future consultation services. I understand that by signing this form I may revoke my consent in writing at any time. As long as this consent is in force (has not been revoked) MSPCC/Eliot Community Human Services may provide services to my child via virtual platform without the need for me to sign another consent form.

Please contact Early Childhood Mental Health Consultation program director, Jayna Doherty, with additional questions at 508-688-5408 or [jdoherty@eliotchs.org](mailto:jdoherty@eliotchs.org).

**Parent Name Print:** \_\_\_\_\_

**Parent Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Dear Parent/Guardian,

The Massachusetts Department of Early Education and Care (EEC), Early Childhood Mental Health Consultants, (ECMHC) and \_\_\_\_\_(the “Program”)

are working together to prevent, identify, and reduce the impact of behavioral and emotional distress upon young children through the use of on-site early childhood mental health consultation and mentoring. In addition, this work includes training and coaching in order to strengthen program leaders, and to strengthen the capacities of administrators and educators capacities to reflect, problem solve, and be effective in their roles to identify risks and prevent or reduce social-emotional and behavioral concerns that might arise.

As part of a broader comprehensive statewide system of mental health supports for children and families, EEC aims to provide a statewide system of ECMHC services. The consultation services funded through this grant are designed to provide support and guidance to programs, educators, and families to address the developmental, social and emotional, and behavioral challenges of infants and young children that will support healthy development, reduce the suspension and expulsion rate in early education and care settings, and promote school success.

The Consent Form below requests your permission to share information, which is not considered personally identifiable information, to EEC in an aggregate format in order for EEC to understand the effect of such services and to provide information on the much needed services for social emotional services supports for children and families.

The Consent Form also requests your permission to share the data with other agencies of the Commonwealth of Massachusetts. The data to be shared will not be connected to a child, classroom, or program. **Please note that we will combine (aggregate) the data of many children and will not identify any specific individual child.** All personally identifiable linked to a specific child **will be confidential to ensure the privacy of your child and you.** If you do not wish to have any information shared, you may decline this option. Declining this such option will have no impact upon child’s early care and education program’s ability able to request support through the Early Childhood Mental Health Consultation, and no information will be shared.

If you choose to participate in the Early Childhood Mental Consultation Supports through your early care and education program, please complete the Consent Form below. Thank you!

## Early Childhood Mental Health Consultation (ECMHC) Family Consent Form

Please read the text below and check the box to indicate whether you permit your child to participate in the Early Childhood Mental Health Consultation Supports:

By checking this box, I acknowledge that I have read the information provided by the Department of Early Education and Care (EEC) about the Early Childhood Mental Health Consultation Supports and:

- **I agree** to have non-identifiable information entered into the ECMHC reporting database, and
- **I agree** to have non-identifiable information shared with the Commonwealth of Massachusetts, and any of its designated agents or assigns, for the purposes of state-wide data collection that reviews only at aggregated data to determine need for future trainings for early childhood professionals, and policies.

By checking this box, I acknowledge that I have read the information provided by the Department of Early Education and Care (EEC) about the Early Childhood Mental Health Consultation Supports and:

- **I do agree** to have my child's non-identifiable information entered into the ECMHC reporting database, and
- **I do not agree** to have my child's non-identifiable information shared with the Commonwealth of Massachusetts and any of its designated agents or assigns.

By checking this box, I acknowledge that I have read the information provided by EEC about the Early Childhood Mental Health Services, and I decline to have my child(s) data entered in the ECMHC database.

\_\_\_\_\_  
Name of Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian