Integrated Case Management (ICM) Meeting FAQs for Caregivers and Referrers

What is Integrated Case Management (ICM)?

A free, voluntary, family-focused, strength-based program that uses a facilitator to bring all relevant people, including providers, family and natural supports, to the table. ICM is designed to assist families to connect with services/supports in the community. This team then works in partnership with the family to create a set of suggestions/recommendations that may help address the needs expressed by the family.

Who attends the ICM Meeting?

The ICM team is comprised of the following representatives from local community organizations and state agencies, including but not limited to: Behavioral Health Resources, Catholic Community Services, Children's Administration, Community Youth Services, Developmental Disabilities Administration, Educational Service District (ESD) 113, Family Alliance for Mental Health, Family Education and Support Services, Juvenile Probation, North Thurston School District, Olympia School District, Thurston County Regional Support Network, and Thurston/Mason Wraparound Initiative. It is the caregiver's decision to determine who is invited to their ICM meeting. This should be indicated in the referral form and release of information form. NOTE: The referrer must also attend, or have a representative attend the meeting.

How can I access the support of the ICM Team?

The referent must complete and submit the ICM referral and a release of information form in order to schedule an ICM meeting. Meetings are held the first Monday and third Thursday of each month. The referral and release of information forms MUST be submitted one week prior to the meeting. Referrals can be sent to Cherise Cain via email at icmatfamilyalliance@gmail.com or fax at 360-438-3575. The referent will be contacted to coordinate the scheduling of the ICM meeting.

What can I expect when attending an ICM Meeting?

The meeting will last for an hour. At the beginning of the meeting, everyone will have the opportunity to introduce themselves. The caregiver/family support member will then share the family's strengths and needs. The ICM team may ask questions to help problem solve. The team will then share appropriate resources in the community that are available to the family for support to address the identified needs and enhance the family's strengths.

What happens following the ICM Meeting?

The ICM team will provide a list of recommendations/suggestions and contact information to the caregiver or current service provider. It is the caregiver's decision of whether or not the support/service recommended by the team will be accessed.

What about the privacy of my family?

Families have the right to receive confidential services. This means that those gathered at the meeting will not discuss your family members and your situation, unless you provide specific permission, by signing a release of information form. There is one important exception to this: if a plan to harm yourself or someone else, as mandated reporters we will report this to proper authorities.

Should I bring my child/teen to the meeting?

Your child/teen is welcome to attend the meeting; however, it is likely that he or she will not participate in the entire meeting as the team prefers to discuss any concerns without their presence. We kindly ask to indicate on the referral form of whether the child/teen will be in attendance so we can provide support/supervision, if necessary.

Where is the meeting held?

Family Education and Support Services
6840 Capitol Blvd. Building 3
Tumwater, WA 98501
(360)754-6529

Integrated Case Management (ICM) Referral Form

Referent/Agency:	**Referent's Phone Number:**
Date Referral Started:	**Scheduled Team Meeting Date:**

1. Referred Youth's Information

Name:	Gender: ☐ Male ☐ Female
Address:	Date of Birth:
	Will the youth be attending the meeting? ☐ Y ☐ N

My Primary Language:	My Secondary Language:
I need an interpreter. ☐ Y ☐ N	I can read English: ☐ Y ☐ N

Medicaid? ☐ Y ☐ N	Insurance? ☐ Y ☐ N	Insurance Provider:

2. Primary Parent or Caregiver Information

Name:	Relationship to Youth:
Name:	Relationship to Youth:
Address of Primary Caregiver(s):	Phone 1: Phone 2: Best time to call: anytime May we leave VM? ☐ Y ☐ N

My Primary Language:	My Secondary Language:
I need an interpreter. ☐ Y ☐ N	I can read English: ☐ Y ☐ N

3. Additional Parent or Caregiver Information

Name:	Relationship to Youth:
Address:	Phone 1: Phone 2: Best time to call: anytime May we leave VM? ☐ Y ☐ N

My Primary Language: English	My Secondary Language:
I need an interpreter. ☐ Y ☐ N	I can read English: ☐ Y ☐ N

4. Current Living Situation of Youth and for How Long?

☐	Two-Parent Family:	☐	Adoptive Family
☐	One Parent Family	☐	Grandparent(s)
☐	Other Relative	☐	Family Foster Care
☐	JRA Facility	☐	Group Foster Care
☐	County Detention	☐	Shelter/Homeless
☐	CLIP Facility or Psychiatric Hospital	☐	Other:

5. What are you most worried about for your child?
6. What type of support/services has your family received in the past and/or currently?
7. What has worked well for you/your family when addressing these needs in the past? If these are new challenges, what do you see as possible solutions?
8. What other assistance/support might your family need?
9. What are three things you are hoping to get out of the ICM meeting?

10. Please identify whom you would like to attend the team meeting?

☐	Mental Health	Agency/Contact:
☐	Child Welfare	Agency/Contact:

☐	Substance Treatment	Agency/Contact:
☐	Division of Developmental Disabilities	Contact:
☐	Juvenile Rehabilitation	Site/Contact:
☐	Parole	Contact:
☐	County Detention	Contact:
☐	Probation	Contact:
☐	Education	School/Contact:
☐	Tribal System	Tribe/ Contact:
☐	Economic Assistance (CSO)	Contact:
☐	Other	Contact:

Please send the referral to Cherise Cain via
email at icmatfamilyalliance@gmail.com or fax 360-438-3575
The referent will be contacted to schedule the ICM meeting.

ICM Thurston County
Authorization for Release and Exchange of Information

Name_____ Date of Birth_____

(NOTE: This form must be completed before it is signed by the clients.)

This document authorizes release/exchange of the information identified below, between the Thurston County Integrated Case Management Team members for the purpose of service/treatment planning coordination, and delivery. This release authorizes the designated person(s)/ agency(ies) listed below to release/exchange information and reports with each other as needed to assess/determine individual and family service needs and to coordinate/monitor/evaluate individual and related family services delivered to client. We will not condition the provision of treatment on execution of an authorization form, except where the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I specifically authorize the following individuals or agencies:

- ☐ Medical Provider :_____
- ☐ Mental Health: _____
- ☐ Thurston County Juvenile Court
- ☐ Public School Districts
- ☐ Children's Administration
- ☐ Juvenile Rehabilitation Administration.
- ☐ DDA:_____
- ☐ Catholic Community Services:_____
- ☐ Families: _____
- ☐ Wrap-Around Team
- ☐ Community Youth Service: _____
- ☐ Thurston County Regional Support Network: _____
- ☐ Other: _____
- ☐ Other: _____

To exchange the following information:

- ☐ Medical Records
- ☐ Psychiatric Treatment/Reports
- ☐ Educational Reports
- ☐ Other _____
- ☐ Mental Health Assessment &Treatment Plans
- ☐ Psychological Records/Reports
- ☐ Legal/Court Records
- ☐ JRA Records
- ☐ Drug & Alcohol
- ☐ Child Welfare Records
- ☐ Communicable Disease

With the following exceptions:

_____ may not be exchanged with _____.
(Individual/Agency)

_____ may not be exchanged with _____.
(Individual/Agency)

Alcohol /Drug, Mental Health, and Medical Records include all aspects of diagnosis, treatment, and prognosis. Educational records indicate both behavioral and progress records.

This authorization is good for one (1) year from date of signature.
I can cancel this authorization in writing at any time prior to the specified expiration, but I understand that the cancellation will not affect my information that was already released before the cancellation. I will let a Care Coordination Team member know if I want to cancel my authorization. I understand that information about my case is confidential and protected by state and federal law. I approve the release of this information. I understand what this agreement means. I am signing on my own and have not been pressured to do so. I understand that information that has been release by an agency is no longer protected by that agency and may be subject to re-disclosure by the recipient, even though further disclosure of this information is prohibited unless permitted by the written authorization of the client, or their parent, guardian, or personal representative.

_____	_____	_____	_____
Signature of Client	Date	Signature of Guardian or Personal Representative	Date
_____	_____	_____	_____
Signature of Witness	Date	Description of Representative's Authority to act for the Client	Date

To those receiving information under this authorization: The information disclosed to you is protected by state and federal law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by other laws.