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

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

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

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

Child Information

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

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

What is the child's primary language? _____ **secondary language?** _____

Early Learning services funded through: □ Child Care Works □ PHL PreK □ PA Pre-K Counts □ IT Contracted Slots □ NA

What other services/systems are involved on behalf of this child? □ EI 0-3 □ EI 3-5 □ Child Welfare
□ Child Mental Health □ Case Management Services □ Head Start □ Home Visiting □ PA Pre-K Counts
□ Rapid Response □ NA

Recent Referrals Made (if any, i.e. EI, MH) _____

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

Early Learning Program Information

Program Name _____ **MPI #** _____

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

Address _____

Phone _____ **Fax** _____ **Email** _____

County _____

STAR Level ☐ STAR 1 ☐ STAR 2 ☐ STAR 3 ☐ STAR 4 ☐ Accredited ☐ NA

Early Learning Resource Center (ELRC) Quality Coach (if known) _____

Classroom Information (for referred child)

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

Classroom Name _____ **Children in classroom (max # allowed)** ____

Age Range (in classroom) _____

TO BE COMPLETED BY CLASSROOM STAFF

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

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

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

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

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

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

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

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

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

THE PENNSYLVANIA KEY

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

Child's Name _____ Child's Date of Birth _____

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

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

Parent/Guardian Signature_____Date _____

Parent/Guardian Signature_____Date _____

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

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Early Learning Program	Site Director Name
Address	County
Email	Phone

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

Program Director Signature _____ Date _____

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Programa de Consulta de Salud Mental Infantil y de Temprana Edad

Acuerdo entre Padres/Tutores y el Programa de Aprendizaje de Temprana Edad

Nombre del niño(a)_____ Fecha de Nacimiento _____

Nombre del padre/madre/tutor	*Nombre del padre/madre/tutor
Dirección	Dirección
Correo electrónico	Correo electrónico
Teléfono	Teléfono
Relación con el niño(a)	Relación con el niño(a)

- Autorizo al Programa de Consulta de Salud Mental Infantil y de Temprana Edad (IECMHC, su acrónimo en inglés) a proveer servicios de consulta a mí y al programa de aprendizaje de mi hijo(a), que incluyen lo siguiente:
  - Observación del entorno de educación temprana y consulta para mí y para los maestros de mi hijo(a) para apoyar el desarrollo socioemocional de mi hijo y mejorar sus experiencias en el entorno de educación temprana.
  - Apoyar la administración de formularios de detección universal para determinar las fortalezas y las áreas de riesgo de desarrollo de mi hijo(a), cuando corresponda.
- Comprendo que el Consultor puede proveerme información sobre inquietudes relacionada al niño(a) y recursos dentro de mi comunidad que podrían ser útiles.
- Comprendo que se mantendrá la confidencialidad de cualquier información sobre mi hijo(a)/familia y que no se compartirá sin un permiso por escrito.
- Acepto que IECMHC pueda recopilar una variedad de datos sobre mí y mi hijo(a) y almacenar estos datos en una base de datos segura. Solo personal autorizado por Pennsylvania Key tendrá acceso a estos datos. Se mantendrá la confidencialidad de todos los datos. Los datos agregados pueden usarse en informes de evaluación o investigación para ayudar la mejora de los servicios de IECMHC.
- Comprendo que el personal de IECMHC está obligado a informar cualquier abuso infantil o violación a la licencia de educación temprana.
- Comprendo que se me invitará a participar en reuniones de equipo y en el desarrollo de un plan de acción colaborativo.
- Comprendo que la consulta es de naturaleza sugestiva y que sigo siendo responsable de las decisiones que tome en nombre de mi hijo(a) y familia. Las sugerencias consultivas compartidas para su consideración no son mandatorios o requisito estatal.
- Comprendo que la participación en IECMHC es voluntaria tanto por parte del niño(a)/familia como del programa de educación temprana. Cualquiera de las partes puede interrumpir la participación en cualquier momento, preferiblemente mediante notificación escrita al consultor.

Firma de padres/tutor _____ Fecha _____

Firma de padres/tutor _____ Fecha _____

Segundo padre/tutor NO REQUERIDO, pero se provee como una opción para ser incluidos.

Nombre del Programa de Temprana Edad	Nombre del director(a)
Dirección	Condado
Correo electrónico	Teléfono

- Autorizo al Programa de Consulta de Salud Mental Infantil y de Temprana Edad (IECMHC, su acrónimo en inglés) a proveer servicios de consulta en mi programa de aprendizaje de temprana edad y como director(a)/administrador(a) del programa haré lo siguiente:
- Me aseguraré de que el Consultor(a) tenga acceso a visitas al aula, observaciones y tiempo para reunirse conmigo y con el personal del aula para analizar las políticas/prácticas que apoyan la equidad, el desarrollo socioemocional y la salud relacionada a los niño(a)s bajo nuestro cuidado.
- Me aseguraré de que el personal del aula y yo estemos disponibles para participar en la comunicación continua con el consultor(a) y la familia y en las reuniones de equipo, ayudaré con la recopilación de herramientas de documentación/resultados y apoyaré la implementación de medidas y recomendaciones desarrolladas por el equipo.
- Acepto mantener la confidencialidad de toda la información revisada, compartida y recibida.
- Comprendo que el personal de IECMHC está obligado a informar cualquier abuso infantil o violación a la licencia de cuidado infantil.
- Comprendo que la consulta es de naturaleza sugestiva y que sigo siendo responsable, ética y legalmente, de las decisiones que tome dentro del entorno del centro educativo. Las sugerencias consultivas compartidas para su consideración no son mandatorios o requisito estatal.
- Comprendo que la participación en IECMHC es voluntaria tanto por parte del niño(a) y familia como del programa de educación temprana. Cualquiera de las partes puede interrumpir la participación en cualquier momento, preferiblemente mediante notificación escrita al consultor.

Firma del director(a) del programa _____ Fecha _____

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