

Family Independence First

Family Empowerment First

Family Engagement First

Family Community First

Family Respect First

Family Support First

Family Culture First

Family Success First

Family Choice First

Family Values First

Family Voices First

Family Vision First

Family Driven First

Family Goals First

Family Focus First

VENDOR SEARCH SOFTWARE

FOR FAMILY VOICES
NETWORK OF ERIE COUNTY,
NEW YORK

Connecting Communities...Focused on Quality



RECEIVING THE SERVICE REQUEST

Referrals from Care Coordination agencies using the Family First Vendor Search Software will appear to come from Eric Maldonado at CCNY, even though they originate from the server itself. The subject line will read “**Family First Provider Request**”, and will look like the email shown below (please be aware that headings may differ, according to email system used):

From: Eric Maldonado
To: darci.hanson@dfa.state.ny.us
Subject: Family First Provider Request

Sent: Mon 6/8/2009 10:58 AM

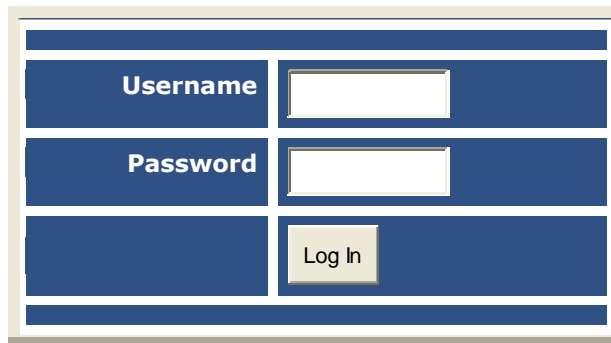
A family has requested your services. The details for this request can be viewed at <https://www.familyfirstny.org>

ACCEPTING OR DECLINING THE SERVICE REQUEST

The Vendor Agency Supervisor, Independent provider, or designated personnel receiving the email should click on the Family First hotlink to go to the Family First website and review the details regarding the case.

The time frame for Accepting or Declining a case is 16 business hours. If a case is not Accepted or Declined once that time frame has expired, the request will immediately go to the next provider that the family chose, and another 16 business hours will begin, until a match is made, and their needs are met.

The website will have the following login screen:



Username	<input type="text"/>
Password	<input type="password"/>
	<input type="button" value="Log In"/>

Using their Username and Password, the Supervisor, Independent, or other designee will be able to review the CASE DETAILS of the client, and determine whether they can fulfill the service requested. These CASE DETAILS are what vendors would normally find in the Universal Referral Form (this software replaces that form). As seen below, these details should be ***printed before accepting case***. NOTE: At the present time,

clicking the “Accept” button will immediately close the program, making the referral page inaccessible.

Once accepted, communication between the provider and CC is ensured in two ways:

1. The supervisor will provide the CC’s contact information to their worker, and
2. The CC will receive an automatically generated email which shows the following:

Provider Gateway-Longview has chosen to accept the terms of this case. Family First recommends you contact them or their Vendor Agency supervisor to coordinate the introduction to the child and/or family.

NOTE: If you are unable to determine who the client and/or the CC or ICC is, call me for verification; I will need the client name and CareManager ID #.

There are some instances where a provider/independent might choose to “Decline”, and those reasons are listed in the **Reason for declination** drop-down box as follows:

- Provider has scheduling conflict
- Provider has conflict of interest
- Provider’s services on hold
- Outside of provider’s geographical area
- Safety Concerns
- Inappropriate Referral
- Provider decline—reason other than listed

Accept or Decline this Case

Accept

Reason for declination

Provider has scheduling conflict

Decline

Case Details

Case #

88

Client Name

Maxwell Smart

Anticipated Length of Service

6 months

Other Info

Two dogs in the home.

Confirmed with Provider?

Service Start Date

6/10/09

Comments

Child Information

Child's nick name

Skippy

Child's date of birth

8/31/98

Child's sex

M

Child's ethnicity

Caucasian

Street address

605 Niagara S

City

Buffalo

Zip

14201

Nearest cross street

Jersey Street

Phone number

(716) 430-336

Name of parent(s)/ legal guardian(s)

Mom

Relationship

Address (if different from above)

Emergency Contact and Relation to the Child

Emergency Contact

Eric Sr.

Relation to Child

Phone Number

Other household members (1)

Name

DOB

Relation to child

Living in the home?

Other household members (2)

Name

DOB

Relation to child

Living in the home?



[Click here to view /enter more than 2 household members](#)



Months in Care Coordination

What is the current situation or mental health status that led to this referral:

Child/Family Relation Information

Strengths

Child's hobbies/interests

Needs

Medical Concerns (any restrictions and/or allergies)

Asthma

Diagnosis

Axis I DX Name

Axis I DX Code

Axis II DX Name

Axis II DX Code

Axis III DX Name

Axis III DX Code

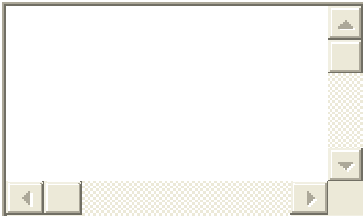
Axis IV DX Name

Axis IV DX Code

Axis V: Recent

Axis V: Last Year

Diagnosis comments



Psychiatric History

Medications

Institution Name

Last placement date

Medical Exam Status

Oriented

Affect

Mood

Lethality Assessment (both current and historical)

Self

Others

Drug/Alcohol History (child and/or family)

Exposure to Trauma (domestic violence, abuse, neglect, etc) (past and/or present)

Weapons in the home?

If yes, what weapons are present

Plan regarding weapons

Is safety a factor when transporting child?

Are there safety concerns with other family members/community?

Please explain the area of focus from the most recent Plan of Care for this Service/Support

Once a match is made, the process is completed, and the Wraparound process begins.