**Wraparound with Intensive Services (WISe)**

**Referral Form**

**This form can be used for any WISe Program for children/youth with Medicaid, including Multisystemic Therapy (MST); Transition Age Youth (TAY) WISe at Community Youth Services (CYS) and WISe provided by Catholic Community Services (CCS).**

**The form can also be used for children/youth without Medicaid in Thurston County only.**

**SERVICES SUPPORTED BY THE MASON/THURSTON WRAPAROUND INITIATIVE**

|  |  |  |
| --- | --- | --- |
| Referral Date:  | Time:  |  |
| Referred By: Affiliation: | Referent Phone: |

Is the youth/child: [ ]   Residing in Thurston or Mason County        [ ] 20 Years of Age or Younger

Insurance: [ ] Actively Enrolled in Medicaid – ProviderOne ID:

[ ] Molina [ ]  Coordinated Care [ ]  Amerigroup [ ]  United [ ]  Community Health Plan of WA

[ ]  Not Eligible for Medicaid

|  |  |
| --- | --- |
| Child/Youth Name:DOB:Gender: [ ] Transgender [ ] Male [ ] Female [ ] Non-Binary [ ] Gender Fluid  | Address:Phone: |
| Race (Check as many as apply): [ ] White [ ] Black of African-Am [ ] Asian [ ] Native Hawaiian or Other Pacific Islander [ ] American Indian or Alaska Native [ ] Other Hispanic Origin? [ ] Yes [ ] No [ ] Choose Not to Respond |
| School: Grade:  | Does this youth have a sibling currently receiving WISe services? [ ] Yes [ ] No |
| Name of Parent(s)/Primary Caregiver(s): If Applicable Has parent/youth been contacted/aware of referral?[ ] Yes [ ]  No  | Phone: |
| Name of Legal Guardian/Caregivers **if different than above:** | Phone: |
| Children/Youth/Family, strengths, interests and/or activities: |
| Reason for Referral: |
| Safety Concerns? |

**Is there a parent, caregiver or natural support available to participate in the wraparound process?**  (if applicable)

[ ] Yes [ ] No

|  |
| --- |
| Complete this section only for **youth 12-17** who exhibit acting out behaviors and who have at least one caregiver willing to engage in treatment to effectively address the youth’s behaviors.Check all that apply:[ ]  Caregiver(s) committed to the youth remaining with them for at least six months[ ]  No mental needs likely to require hospitalization in the near future[ ]  No Level 2 or Level 3 Autism Spectrum Disorder diagnosis.[ ]  No developmental/intellectual disabilities directly related to/or cause of behaviors.If all of the items above have been checked, this referral will likely be sent to the Multisystemic Therapy Program at Community Youth Services for review. |

**Is the family currently receiving intensive or in-home therapy/treatment?** If so, please describe:

**Systems and Issues known to be involved with the Child/Youth:**

**Legal/Justice**: [ ] Yes [ ] No

Number of Arrests in the last 12 months:

Number of Convictions in the last 12 months:

At risk for Legal/Justice reasons:

**Receiving Outpatient Mental Health Services**: [ ] Yes [ ] No

**If Yes**Circle or Check**:**[ ] BHR [ ]  SeaMar [ ] Consejo[ ]  True North

[ ] Catholic Community Crisis Services

Number of emergency room (ER) visits related to health concerns in last 12 months:

* If ER visits listed, was mental health a primary factor for any visit:  [ ] Yes [ ] No   (choose one)
* Was substance abuse a factor in any of these ER visits: [ ] Yes [ ] No   (choose one)

At risk for Mental Health need:

**Substance Use Issues:** [ ] Yes [ ] No  **Receiving Outpatient Treatment**: [ ] Yes [ ] No

At risk for substance use reasons:

**Department of Children, Youth and Families:**[ ] Yes [ ] No

**Program Enrollment**- Check any/all that apply: [ ]  Foster Care [ ]  Child Protective Services [ ]  Family Reconciliation Services

 [ ]  Child Welfare [ ]  Behavioral Rehabilitation Services  [ ]  Family Preservation Services

 [ ]  Other (describe):

**Developmental Disabilities Administration Enrollment:**[ ] Yes [ ] No

Current Services:

**School Challenges:** [ ] Yes [ ] No

Truancy? [ ] Yes [ ] No

Suspended/Expelled: [ ] Yes [ ] No Reason (if known):

Current IEP/504/ Behavior Plan/Contract: [ ] Yes [ ] No  [ ] Unknown

**Child/Youth/Family and Natural Support Contact Information:**

Please list additional family members, friends, supportive individuals or professionals involved with the child/youth that may want to participate on the wraparound team.  Include contact information if available and list any known contact restrictions:

|  |  |  |  |
| --- | --- | --- | --- |
| **Name**  | **Relationship**  | **Address/Phone**  | **Comments**  |
|   |   |   |   |
|   |   |   |   |
|   |    |   |   |
|   |   |   |   |

PLEASE COMPLETE IF THE YOUTH IS **AGE 13 OR OLDER** ***AND*** PARTICIPATING IN COMPLETING THIS REFERRAL FORM

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,  consent to having the following individuals contacted concerning eligibility and admission into WISe:

[ ]  Referent (Whomever is helping to fill out and fax this form in for you)

[ ]  Parent/Legal Guardian/Caregiver

[ ]  Individuals listed as possible wraparound team members

[ ]  Probation/Parole Counselor:

[ ]  School:

[ ]  Others that may help us reach you:

Youth Signature:

                Date:

Witness Signature (referent):

 Date:

**Please fax completed form to Donna Obermeyer, WISe Coordinator at 360-489-0402**

**For More Information Contact:**

|  |  |  |
| --- | --- | --- |
| Donna ObermeyerWISe Coordinator (360) 790-7505 familyalliancewashington@gmail.com   | **Catholic Community Services** **Family Behavioral Health**  Heidi Knadel 360-878-8248  HeidiKn@ccsww.org  | **Community Youth Services** Multi-Systemic Therapy Allison Graff, Program Supervisor 360-628-3687agraff@communityyouthservices.orgTransitional Age YouthCarrie Mayeux, Program Director360-489-5562cmayeux@communityyouthservices.org **Referrals:** 360-918-7860  icd@communityyouthservices.org |

The next page is optional.

**Please complete the following to the best of your knowledge (not required/optional):**

|  |
| --- |
| **CROSS SYSTEM INVOLVEMENT:***When was youth’s****most recent****involvement with the following?*  |
| Current   | Past 30 days   | Past 12 months   | More than 12  months ago   | Never   | Don’t know   | Most recent involvement in . . .   | Provider/Agency/Detail (Include phone number if possible)  |
|[ ] [ ] [ ] [ ] [ ] [ ]  Behavioral Rehabilitation Services   | Pre-BRS Screen?   |
|[ ] [ ] [ ] [ ] [ ] [ ]  Foster Care   |     |
|[ ] [ ] [ ] [ ] [ ] [ ]  Other Department of Children, Youth & Families *(CPS, FRS, Child Welfare)*  | Social Worker:   Contracted Provider Services?     |
|[ ] [ ] [ ] [ ] [ ] [ ]  Juvenile Justice *(Arrests, Probation, Detention, Dispositional Alternatives)*  | PO:    |
|[ ] [ ] [ ] [ ] [ ] [ ]  Juvenile Rehabilitation *(JJ&RA Institution, Parole)*  | Detail:    |
|[ ] [ ] [ ] [ ] [ ] [ ]  Special Education   |    |
|[ ] [ ] [ ] [ ] [ ] [ ]  Developmental Disabilities Administration   | Case Manager:    |
|[ ] [ ] [ ] [ ] [ ] [ ]  Substance Abuse – Outpatient Treatment   | Where:    |
|[ ] [ ] [ ] [ ] [ ] [ ]  Substance Abuse – Inpatient Treatment   | Where:    |
|[ ] [ ] [ ] [ ] [ ] [ ]  Substance Abuse – Detox   | Where:    |
|[ ] [ ] [ ] [ ] [ ] [ ]  Mental Health – Outpatient Treatment – **Non-Medicaid**  | Current Provider:   Past Provider:    |
|[ ] [ ] [ ] [ ] [ ] [ ]  Mental Health – Outpatient Treatment – **BHR, Sea Mar, Consejo** **CYS, CCS, True North**  | Current Provider:   Past Provider:    |
|[ ] [ ] [ ] [ ] [ ] [ ]  Mental Health – CLIP  Childrens Long Term Inpatient Program  | Where:   |
|[ ] [ ] [ ] [ ] [ ] [ ]  Mental Health – Other Inpatient Treatment *(Psychiatric Hospitalizations, State Hospitals)*  | Where:  |
|[ ] [ ] [ ] [ ] [ ] [ ]  Mental Health – Crisis Service   | Provider:   |
|[ ] [ ] [ ] [ ] [ ] [ ]  School-Based Behavioral Health Services-mental health/drug-alcohol  | Counselor:    |
|  |  |  |  |  |  | Tribal Behavioral Health Services   | Tribe:  |