**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).**

 **It 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:[ ]  Actively Enrolled in Medicaid [ ]  Residing in Thurston or Mason County [ ]  Under the age of 21 [ ]  Not Eligible for Medicaid**Provider 1 # Molina \_\_ Coordinated Care \_\_ Amerigroup \_\_ United \_\_ CHPW\_** |
| Child/Youth Name:  DOB: Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_Transgender\_\_\_Male\_\_\_ Female\_\_\_ Non-Binary\_\_\_ Gender Fluid\_\_\_ | Address: Phone:  |
| School: Grade: Race (check as many as apply): White\_\_ Black or African-Am\_\_ Asian\_\_ Native Hawaiian or Other Pacific Islander\_\_ American Indian or Alaska Native\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_Hispanic origin ? Yes\_\_\_ No\_\_\_ Choose Not to Respond\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | jjllDoes this youth have a sibling currently receiving WISe services?  |
| Name of Parent(s)/Primary Caregiver(s): (if applicable) Has parent/youth been contacted/aware of referral? Yes [ ]  No [ ]   | Phone:  |
| Name of Legal Guardian/Caregiver(s) **if different than above**:Children/Youth/Family, strengths, interests and/or activities:  | Phone:  |
|  |
|  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 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 health 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 [ ]

Sea Mar [ ]  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 (circle one)
* Was substance abuse a factor in any of these ER visits: Yes/No (circle one)

At risk for Mental Health need:

**Drug and/or Alcohol Issues:** Yes  **[ ]** No **[ ]  Receiving Outpatient Treatment:** Yes [ ]  No [ ]

At risk for Drug/Alcohol reasons:

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

**Program Enrollment**- Circle any/all that apply: Foster Care; Child Protective Services, Family Reconciliation Services; Child Welfare; Behavioral Rehab Services; Family Preservation Services; Other (describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Current Services:

**School Challenges:** Yes [ ]  No [ ]

Truancy? 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):

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

**For More Information Contact:**

|  |  |  |
| --- | --- | --- |
| Donna Obermeyer, WISe Coordinator(360) 790-7505familyalliancewashington@gmail.com  | **Catholic Community Services****Family Behavioral Health**Heidi Knadel, Director  360-878-8248HeidiW@ccsww.org | **Community Youth Services**Multi-Systemic Therapy Allison Graff, Program Supervisor 360-918-7853agraff@communityyouthservices.orgTransitional Age YouthCarrie Mayeux, Program Director Referrals: 360-918-7860  icd@communityyouthservices.org |

**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 *(Long Term Incarceration/Parole)*  | Detail: |
|  |  |  |  |  |  | Special Education  |  |
|  |  |  |  |  |  | Developmental Disabilities Administration  | Case Manager: |
|  |  |  |  |  |  | Substance Use Disorder Outpatient Treatment  | Where: |
|  |  |  |  |  |  | Substance Use Disorder Inpatient Treatment  | Where: |
|  |  |  |  |  |  | Substance Use Disorder 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: |