**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\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | jjll  Does 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:** YesNo

**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** |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |

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