**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** |
|  |  |  |  |
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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):

Date:

**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   360-878-8248   HeidiKn@ccsww.org | **Community Youth Services**  Multi-Systemic Therapy  Allison Graff, Program Supervisor  360-628-3687  agraff@communityyouthservices.org  Transitional Age Youth  Carrie Mayeux, Program Director 360-489-5562  [cmayeux@communityyouthservices.org](mailto:cmayeux@communityyouthservices.org)  **Referrals:** 360-918-7860  [icd@communityyouthservices.org](mailto: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: |