



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** with caregivers who want treatment focused on empowering them with the skills and resources needed to independently address the difficulties parenting youth with anti-social 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 Autism Spectrum Disorder
- No developmental/intellectual disabilities directly related to/or cause of behaviors.

If all of the items above have been checked, please contact Multisystemic Therapy Program Director Tricia Wiltse at Community Youth Services 360-918-7889.

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:

**Mental Health:** Yes  No  **If Yes** Circle or Check One BHR  Sea Mar

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

At risk for Drug/Alcohol reasons:

**Division of Children & Family Services:** 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) \_\_\_\_\_

**Division of Developmental Disabilities:** 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

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

<b>CROSS SYSTEM INVOLVEMENT: When was youth's most recent involvement with the following?</b>							
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)
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Behavioral Rehabilitation Services	Pre-BRS Screen?
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Foster Care	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other Children's Administration Services (CPS, FRS, Child Welfare)	Social Worker: Contracted Provider Services?
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Juvenile Justice (Arrests, Probation, Detention, Dispositional Alternatives)	PO:
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Juvenile Rehabilitation (JJ&RA Institution, Parole)	Detail:
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Special Education	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Developmental Disabilities Administration	Case Manager:
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Substance Abuse – Outpatient Treatment	Where:
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Substance Abuse – Inpatient Treatment	Where:
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Substance Abuse – Detox	Where:
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Mental Health – Outpatient Treatment – <b>Non-BHO</b>	Current Provider: Past Provider:
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Mental Health – Outpatient Treatment – <b>BHO, i.e. BHR, Sea Mar, CYS, CCS</b>	Current Provider: Past Provider:
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Mental Health – CLIP Childrens Long Term Inpatient Program	Where:
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Mental Health – Other Inpatient Treatment (Psychiatric Hospitalizations, State Hospitals)	Where:
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Mental Health – Crisis Service	Provider:
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	School-Based Behavioral Health Services-mental health/drug-alcohol	Counselor:
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Tribal Behavioral Health Services	Tribe:

## 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 (Whoever 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: \_\_\_\_\_
- Other's 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:

<p>Donna Obermeyer, WISe Coordinator (360) 790-7505 <a href="mailto:familyalliancewashington@gmail.com">familyalliancewashington@gmail.com</a></p>	<p><b>Catholic Community Services Family Behavioral Health</b></p> <p>Heidi Williams 360-878-8248 <a href="mailto:HeidiW@ccsw.org">HeidiW@ccsw.org</a></p>	<p><b>Community Youth Services</b></p> <p>Multi-Systemic Therapy: Tricia Wiltse 360-918-7889 <a href="mailto:twiltse@communityyouthservices.org">twiltse@communityyouthservices.org</a></p> <p>Transitional Age Youth: Athena Grijalva 360-918-7891 <a href="mailto:agrijalva@communityyouthservices.org">agrijalva@communityyouthservices.org</a></p>
--	--	--