**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); Transitional 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 for MST at CYS and Wraparound at CCS.**

**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  ***Please note:*** *If any of the above criteria are not met, the youth/child is not eligible for WISe*  **Provider 1 #**   |  | | --- | | For MTWI Use Only: Does the P1 Managed Care Information section indicate Thurston-Mason BHO capitated?  yes  no If no, family must report “change of circumstance” (i.e., address change) to HCA (by calling 877-501-2233 or on-line) before starting WISe services. | | | | | |
| Child/Youth Name:    DOB: Gender: M/F | | Address:  Phone: | | |
| School:  Grade:  Race (circle 1): White African-Am Asian-Am Hispanic origin ? Yes No  Native-Am Bi-racial (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | jjll  This space for MTWI Use Only |
| 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** 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 OneBHR  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:** 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) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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):**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 Children’s Administration Services *(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-BHO** | Current Provider:  Past Provider: |
|  |  |  |  |  |  | Mental Health – Outpatient Treatment – **BHO, i.e. BHR, Sea Mar,**  **CYS, CCS** | 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: |

**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 REFERAL 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:

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:**

|  |  |  |
| --- | --- | --- |
| Donna Obermeyer, WISe Coordinator  (360) 790-7505  familyalliancewashington@gmail.com | **Catholic Community Services**  **Family Behavioral Health**  Heidi Williams  360-878-8248  HeidiW@ccsww.org | **Community Youth Services**  Multi-Systemic Therapy:  Tricia Wiltse 360-918-7889  [twiltse@communityyouthservices.org](mailto:twiltse@communityyouthservices.org)  Transitional Age Youth:  Alicia Ferris 360-918-7876  [aferris@communityyouthservices.org](mailto:aferris@communityyouthservices.org) |