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:
Race (circle 1): White African-Am Asian-Am Native-Am Bi-racial (specify): _____	Hispanic origin ? Yes No
School: Grade:	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**:	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 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):

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)
O	O	O	O	O	O	Behavioral Rehabilitation Services	Pre-BRS Screen?
O	O	O	O	O	O	Foster Care	
O	O	O	O	O	O	Other Children's Administration Services *(CPS, FRS, Child Welfare)*	Social Worker: Contracted Provider Services?
O	O	O	O	O	O	Juvenile Justice *(Arrests, Probation, Detention, Dispositional Alternatives)*	PO:
O	O	O	O	O	O	Juvenile Rehabilitation *(JJ&RA Institution, Parole)*	Detail:
O	O	O	O	O	O	Special Education	
O	O	O	O	O	O	Developmental Disabilities Administration	Case Manager:
O	O	O	O	O	O	Substance Abuse – Outpatient Treatment	Where:
O	O	O	O	O	O	Substance Abuse – Inpatient Treatment	Where:
O	O	O	O	O	O	Substance Abuse – Detox	Where:
O	O	O	O	O	O	Mental Health – Outpatient Treatment – **Non-BHO**	Current Provider: Past Provider:
O	O	O	O	O	O	Mental Health – Outpatient Treatment – **BHO, i.e. BHR, Sea Mar, CYS, CCS**	Current Provider: Past Provider:
O	O	O	O	O	O	Mental Health – CLIP Childrens Long Term Inpatient Program	Where:
O	O	O	O	O	O	Mental Health – Other Inpatient Treatment *(Psychiatric Hospitalizations, State Hospitals)*	Where:
O	O	O	O	O	O	Mental Health – Crisis Service	Provider:
O	O	O	O	O	O	School-Based Behavioral Health Services-mental health/drug-alcohol	Counselor:
O	O	O	O	O	O	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 Transitional Age Youth: Alicia Ferris 360-918-7876 aferris@communityyouthservices.org