CFP SERVICE
ACCESS CENTER REFERRAL FORM

Eligibility Criteria for Wraparound

A child/youth ages 0-21 with a Mental Health diagnosis, who has experienced moderate/severe functional impairments measured by the CAFAS/PECFAS/DECA-C for a period of 6 months *and* **two** or more of the following criteria:

- ☐ involved in multiple child/youth serving systems
- ☐ at risk for out-of-home placements or currently in out-of-home placement
- ☐ has been served through other mental health services with minimal improvement in functioning
- ☐ risk factors exceed capacity for traditional community-based options
- ☐ numerous providers are serving multiple children/youth in the family and the identified outcomes are not being met

** Consult with your supervisor, mental health liaison and/or DeWanna Lancaster, CFP Service Coordinator, with questions around potential referrals.*

Indicate CFP Service requested on behalf of the child/youth/family: ☐ Wraparound ☐ SED Waiver (foster youth only, ages 0-17)

Medicaid status is active and was verified prior to referral: ☐ yes - CONTINUE ☐ no – CONTACT DEWANNA LANCASTER

1. **Child/youth name:** ____
   Last **First** **MI**
2. **Network 180 #:** ________________________ **Age:** ____________
3. **What sex was the youth assigned at birth, on the original birth certificate?** **Male:** _____ **Female:** _____
4. **Current gender identify: how does the youth describe themselves? (Check one)**
   ☐ Male ☐ Female ☐ Transgender ☐ Does not identify as female, male, or transgender
5. **Sexual Orientation:** ☐ Heterosexual/Straight ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Unknown/Other
6. **Is the child of Hispanic or Latin cultural/ethnic background?** ☐ Yes ☐ No
   If YES: Which group describes his/her Hispanic or Latin cultural/ethnic background?
   ☐ Mexican, Mexican-American, or Chicano ☐ Central American ☐ Puerto Rican
   ☐ South American ☐ Cuban ☐ Dominican ☐ Other Hispanic origin - specify ____________________
7. **Which best describes the child?** Is he/she… *(Select all that apply)*
   ☐ American Indian ☐ Asian ☐ Black or African American ☐ White ☐ Alaska Native
   ☐ Native Hawaiian or Other Pacific Islander ☐ Other please specify: ____________________
8. **Placement at time of referral (check all that apply):** ☐ Home ☐ Residential ☐ Psychiatric Hospital ☐ Detention
   ☐ Foster Care (Specify ☐ Relative Placement ☐ Non-relative Placement) ☐ Other: ____________________
   ☐ Guardian Placement (Specify: ☐ Relative Placement ☐ Non-relative Placement)
9. **Name of legal guardian or responsible party**: ____
   Relationship to Child: ____________________ email: ______________________________
10. **Indicate the systems child is presently receiving services or supports: (*CFP Criteria: at least 2 systems*)** *Please fill information completely*

☐ **Juvenile Justice:** ☐ Adjudicated ☐ Non-adjudicated Probation Officer: ____________________

☐ **DHHS (Public Child Welfare)**:
☐ Current/open Child Abuse and Neglect Investigation ☐ Out-of-home Placement ☐ Kinship Care
☐ Residential Treatment ☐ In-home Services (specify) ______________________
DHHS Worker: ______________________ Phone: ______________

☐ **Foster Care** Agency: ________________ Worker: ______________________________

☐ **Mental Health Service Authorized** (home based, outpatient, etc.): ______________________
Agency: ____________________ Date of intake: ______________

☐ **Education** ☐Special Education ☐504 Behavioral Plan Other: ______________________
School Contact & Role: ____________________ Phone: ______________

Name of Clinician completing CFP referral: ______________________**Date Referral submitted:** ____________

DeWanna Lancaster, *CFP Service Coordinator* 616.204.4321 Dewanna.lancaster@network180.org

Community Family Partnership Services
CONSENT FOR EXCHANGE OF CONFIDENTIAL INFORMATION BETWEEN ORGANIZATIONS

I hereby authorize Network180, Arbor Circle, and Wedgwood, to facilitate a referral for CFP System of Care services for the ________________________________ family with the Kent County Wraparound Community Team which may consist of:

ORGANIZATION

Network180	Kent ISD	Parent Support Partners	WMPC – West Michigan Partnership for Children
Arbor Circle	Kent County Court	Department of Health & Human Services	
Wedgwood Christian Services	Youth Advocate		

1) INFORMATION TO BE EXCHANGED:
   a. Information about the family's needs and previous services related to the Wraparound process and engaging a parent support partner. This may include information related to mental health, substance abuse and/or information about serious communicable diseases (HIV/AIDS, Tuberculosis, and Venereal Disease) if this information directly affects the Wraparound plan or parent support partner engagement process.

2) THIS INFORMATION IS TO BE USED ONLY FOR THE FOLLOWING PURPOSE:
   a. To request initial authorization of Wraparound Services and Parent Support Partner.
   b. Wraparound plan review for compliance with Michigan's Best Practice Values and the Wraparound Process components.
   c. When the child and family team need additional information regarding strategies and financial resources.
   d. To request continuation of services at six-month intervals this must occur for compliance of contract obligations.

Further release of this information is prohibited. Any person receiving information from the Wraparound Coordinator shall be so advised.

INITIAL HERE:____ I have read this form and/or have had it read to me and explained in language that I can understand. I authorize the release of this information to the organizations listed above.

INITIAL HERE:____ I give permission for my Wraparound Coordinator and/or Parent Support Partner to communicate information to me regarding my child and my family via encrypted email. I understand that this decision will have no impact on my ability to receive services.

The Community Family Partnership (CFP) provides care for families by coordinating services and supports with agencies in Kent County. This includes Wraparound services, Parent Support Partners, or peer-to-peer supports. CFP coordinates with agencies that work in mental health care, juvenile justice, child welfare, and schools. For example, Arbor Circle, Wedgwood Christian Services, and Wellspring Lutheran Services.

As part of your participation with CFP, client records review and surveys/interviews will be done to understand the impact of CFP services. Iteration Evaluation has been hired to evaluate CFP. The goal of the CFP Evaluation is to understand if CFP services are effective and if they need to be changed to best help families reach their goals.

The CFP evaluation uses three types of information that you will be consenting to:

1. Client records from network180: Your network180 personal and health information forms or records will be shared with Iteration Evaluation. This includes information on the referral, intake, exit, and other administrative and program forms. This also includes CFP services and diagnoses.
2. TRAC Surveys/Interviews: Every 6 months, as a part of your Wraparound services, you will be asked some questions about your family's health and your satisfaction with Wraparound services. You will always be asked if you would like to participate.
3. TOMs observations: An overall observation of your family's Wraparound services to see if the Wraparound team is providing the best services to your family. You will always be asked if you would like to participate.

Evaluation procedures are designed to keep your information confidential. The evaluation results are not identifiable. Iteration Evaluation shares project results and reports with CFP. CFP values families and the results and will publish the results with partners so they understand the effectiveness of the services.

By signing this form:

- I understand that I have read this form or it has been read to me.
- I authorize the release of this information to Iteration Evaluation.

*******Please see the back of this consent form for parent signature. Thank you. *******

By signing this form:

- I understand that I have read this form or it has been read to me.
- I authorize the release of this information to the Iteration Evaluation.

Names of Children/Youth (please print):	network180 ID:

To be completed by Caregiver/Guardian:

Caregiver/Guardian Name (please print): ____

Caregiver/Guardian Signature (please sign): ____

Date signed: | _ _ | **/** | _ _ | **/** | _ _ _ _ |

Exchange Obtained by: ____